

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. In case of death, write the causes of death clearly and legibly. It is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 352

CERTIFICATE OF DEATH

Reg. Dist. No.

10600
40

1. PLACE OF DEATH:

County.....

Allegany

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

40 yrs

Hospital, institution, or street address where death occurred:

734 W. Mechanics St.

How long in hospital or institution?.....

3. (a) FULL NAME

William Edward Arnold

3. (b) Social Security Number

None

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Widowed

6.(b) Name of husband or wife

Elizabeth Kriegmann

7. Birth date of deceased (mo., day, yr.)

April 1, 1861

6.(c) If alive, give age.....years

years

7. Birth date of deceased (mo., day, yr.)

April 1, 1861

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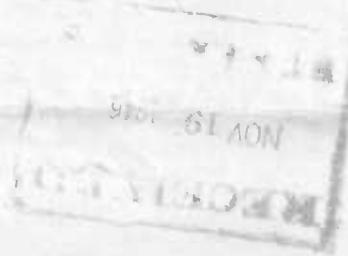
April 1, 1861

years

7. Birth date of deceased (mo., day, yr.)

April 1, 1861

-18-C



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10601
80

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:

County

City or town

Charles Barclay

Baltimore

How long in above place of death?

40 years

Hospital, institution, or street address where death occurred:

76 Douglas Lane Avenue

How long in hospital or institution?

3. (a) FULL NAME

Charles Barclay

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married
Beesie Reives

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 13, 1878

8. AGE: Years Months Days If less than one day
68 1 5 hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation Coal Miner Retired

11. Industry or business

Petroleum Mine

12. Name

Robert Barclay

Robert Barclay

Robert Barclay

Robert Barclay

13. Birthplace

Scotland

14. Maiden name

Mary Frazier

15. Birthplace

Scotland

16. Informant

Wilson Reives

Address

Baltimore

(Burial, cremation, or removal, Which?)

Oak Hill Cemetery

Cemetery or crematory

Baltimore

Location

Baltimore

18. Funeral director

M. Eichhorn

Address

Baltimore

Nov. 20 1946

Janette M. Reives

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No. 76 Douglas Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18

1946 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. to 19.

and that I last saw him alive on Sept. 15

19. 46

Immediate cause of death

Relation of heart

Due to Chronic Bronchial Asthma

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

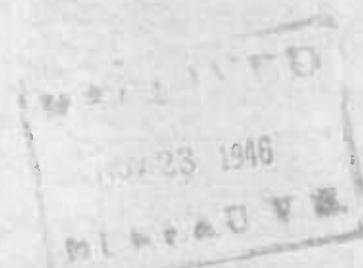
Means of injury Injured at work?

23. SIGNATURE Henry M. Hodges M.D.

M. D. or other

Address Lonaconing, Md.

Date signed Nov. 20 1946



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(BD)*

CERTIFICATE OF DEATH

16602

40

Reg. Dist. No.

1. PLACE OF DEATH:
 County..... Allegany County
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 H.R.
 Hospital, institution, or street address where death occurred: Allegany Hospital
 How long in hospital or institution? 11 Hrs. and 35 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... West Virginia County..... MORGAN
 City or town..... Paw Paw
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... WORLD WAR I

3. (a) FULL NAME
 Constantine Bevans
 4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced
 Married
 6. (b) Name of husband or wife..... Ruth WENTLING
 7. Birth date of deceased (mo., day, yr.)..... June 15, 1893 6. (c) If alive, give age..... years
 8. AGE: Years..... 53 Months..... 4 Days..... 17 If less than one day
 .hrs..... .min.....
 9. Birthplace..... West Virginia
 (Town, county, and state)
 10. Usual occupation..... MERCHANT
 11. Industry or business
 12. Name..... DANIEL BEVANS
 MOTHER FATHER 13. Birthplace..... W.VA.
 14. Maiden name..... BRIDGET McCORMICK
 15. Birthplace..... W.VA
 16. Informant..... MRS. C. W. BEVANS
 Address..... PAW PAW W.VA.
 17. BURIAL..... Date thereof... NOV. 4 '46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... ST. MARY'S BURIAL PARK
 Location..... RURAL CUMBERLAND M.D.
 18. Funeral director..... LOUIS STEIN INC.
 Address..... CUMBERLAND MD.
 19. Nov. 3, 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number
None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 2, 1946, at 2:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-1-46 to 11-2-46 and that I last saw him alive on 11-2-46.

Immediate cause of death.....

Myocarditis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

J. P. Johnson, M.D. or other
 Address..... CUMBERLAND MD. Date signed..... Nov. 3, 1946

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10603

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Allegany
City or town Eckhart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Bollinger

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife Elizabeth Bollinger

7. Birth date of deceased (mo. day, yr.) May 13, 1900 6.(c) If alive, give age 51 years

8. AGE: Years Months Days If less than one day
46 5 20 hrs. min.9. Birthplace Eckhart, Allegany, Maryland
(Town, county, and state)

10. Usual occupation retired

11. Industry or business Celanese Corporation

12. Name George Bollinger

13. Birthplace France

14. Maiden name Anna M. Felklin

15. Birthplace Switzerland

16. Informant Mrs. George Bollinger

Address Eckhart, Md.

17. Burial Date thereof Nov. 5, 1946
(Burial, cremation, or removal. Which?)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director J. J. Durst.

Address Frostburg, Md.

19. 11-5 19. 46
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-01-6688

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2

19. 46, 11. 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Nov. 2

19. 46

Immediate cause of death

Chronic Endocarditis about 5 yrs.

Due to

Due to arthritis about 6 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Nature of injury

Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland, Md. Date signed 11/3/46

Deputy Medical Examiner - Allegany Co.



1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10604
(70-e)

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County.....

Allegany

City or town.....

Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

12 hours

Hospital, institution, or street address where death occurred:

Miners Hospital

How long in hospital or institution?

12 hours

3. (a) FULL NAME

Richard Brinegar

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

deceased (mo., day, yr.)

Nov 11, 1929

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Midland Allegany Co., Md.

(Town, county, and state)

10. Usual occupation

Buckboard Worker

11. Industry or business

Kelleys Springfield Tires

12. Name

Thor Edal Brinegar

13. Birthplace

Petersburg, Va.

14. Maiden name

Catherine Hammersmith

15. Birthplace

Cumberland, Md.

16. Informant

Mrs. Catherine Brinegar

Address

Midland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 15, 1946

(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

18. Funeral director

J. N. Eichhorn

Address

Loracrossing, Md.

19. (Date rec'd by registrar)

46 M. Dailey A. Roe

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Paradise Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

218-24-9563

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1946 at 10:53 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10... to

10...

and that I last saw him dead Nov 12 10:46

Immediate cause of death

Pulmonary Hemorrhage

DURATION

14 hrs

Due to Fractured ribs

Automobile accident. Was driving too

Due to fast, failed to make a curve

eng. 50

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place, (where?)

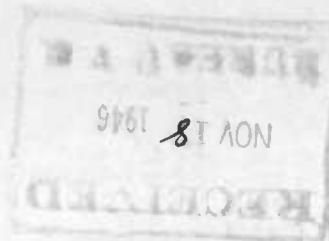
Means of injury Auto accident injured at work?

23. SIGNATURE

H. V. Dameng MD M. D. or other

Address Cumberland, Md. Date signed 11/17/46

Deputy Medical Examiner - Allegany Co



1-35-

within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

10605

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County

Allegany
Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 yrs

Hospital, institution, or street address where death occurred:

501 Oldtown Rd.

How long in hospital or institution?

3. (a) FULL NAME

Mary Julia Brinker

4. Sex

5. Color or race

6(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife

Fredrick L. Brinker

7. Birth date of deceased (mo., day, yr.)

April 8 1898

6.(c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

48 7 22 hrs. min.

9. Birthplace

Cumberland Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At Home

12. Name

Frank Schutz

13. Birthplace

Germany

14. Maiden name

Burtha Holtzman

15. Birthplace

Germany

16. Informant

Fredrick L. Brinker

Address

Cumberland

17. Burial

Date thereof Dec 3 46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St Peter & Pauls Cem.

Location

Cumberland

18. Funeral director

Louis Stein Inc

Address

Cumberland

19. Nov 30

19 46 Joseph D Franklin M

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 501 Oldtown Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 30

19 46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 19 to December 29 1946
and that I last saw h. m. alive on December 29 1946

Immediate cause of death

Carcinoma of breast

DURATION

1 yrs 10 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

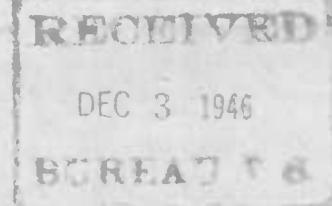
Injured at work?

23. SIGNATURE

J. T. Johnson Jr., M.D.
Cumberland, Md. Date signed 11-30-46

M. D. or other

Address



1-35

Within corporate limits*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. No correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10606

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

209 Grand Ave.

How long in hospital or institution?

3. (a) FULL NAME

Laura V. Carroll

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Robt. W. Carroll

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1864

8. AGE: Years 82 Months 6 Days 25 If less than one day hrs. min.

9. Birthplace West Va. (Town, county, and state)

10. Usual occupation Matron (B&O Station)

11. Industry or business

12. Name Will T. Kelley

13. Birthplace West Va.

14. Maiden name Hulda Sisler

15. Birthplace West Va.

16. Informant A. W. Carroll

Address 304 Arch St.

17. Burial Date thereof Nov. 10, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland Md.

Nov. 9, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 209 Grand Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

705-12-1609

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1946 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 1946 to Nov. 8 1946 and that I last saw her alive on Nov. 7 1946

Immediate cause of death

Carcinomatosis

Due to Carcinoma of Rectum

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Carcinoma of rectum Date of op. Jan 1944

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Franklin, M.D. or other

Cumberland Nov. 11-46 Date signed

Address

RECEIVED

NOV 13 1948

WPA LIBRARY

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 11407

Reg. Dist. No. 9

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

24 hours

Hospital, institution, or street address where death occurred:

Seward Hospital

How long in hospital or institution?

24 hours

3. (a) FULL NAME

Harry H. Cator

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

Married

6. (b) Name of husband or wife

Sarah Brown

6. (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.)

July 10 - 1892

8. AGE:

Years

Months

Days

If less than one day

54

4

7

hrs.

min.

9. Birthplace

Yancey County

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Clay Company

FATHER

12. Name

Charles Cator

13. Birthplace

Tennessee

14. Maiden name

Barbie Gaston

15. Birthplace

Tennessee

16. Informant

Miss Harry H. Cator

Address

P. O. Box 13 of 313 Frostburg

Beds

Date thereof 11-17-1946
(month) (day) (year)

17. Burial

Cemetery or crematory Funeral Cemetery

Location

Frostburg

18. Funeral director

Denton Draper

Address

Frostburg

19. 11-16

1946 Miss Harry H. Rae

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

City or town

Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

P. O. Box 13

Frostburg

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

213-05-7079

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 14 1946 at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1944 to Jan 14 1946

and that I last saw h. m. alive on Jan 13 1946

Immediate cause of death

Exacerbation of heart failure

Due to... Dilatosis

Due to... Cardiac arrest due to

Fire clay worker for 20 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of...

Where did injury occur? (City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

F. G. Murray, M.D.

Timberland Inn Date signed Jan 14 1946



Within corporate limits
DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

10608

40

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH ALLEGANY

County CUMBERLAND, MD.

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

3. (a) FULL NAME

MR. STEVE GOMA

Choma

4. Sex
MALE

5. Color or race
WHITE

6. (a) Single, married, widowed, or divorced
WIDOWED

6. (b) Name of husband or wife ANNA Margae

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Unknown

8. AGE: Years Months Days If less than one day
66 ? ? hrs. min.

9. Birthplace RUSSIA (Town, county, and state)

WOLFTON MINING CO.

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name PETE Choma
13. Birthplace " Austria

MOTHER
14. Maiden name ANN " Unknown

15. Birthplace "

16. Informant O. F. Sharpless

Address Blaine, W. Va.

Burial Date thereof 1130/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Kalbaugh Cemetery

Location Elk Garden, W. Va.

18. Funeral director O. F. Sharpless

Address Blaine, W. Va.

Nov. 29, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

MARYLAND

State SHALLMAR County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

236-12-0297

MEDICAL CERTIFICATION

NOVEMBER 28, 1946

12:05 A.M.

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 8, 1946, to Nov. 28, 1946,

and that I last saw him alive on Nov. 27, 1946

Immediate cause of death

Carcinoma stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. Williams, M.D. M. D. or other
Cumberland, Md. Date signed Nov. 28, 1946

RECEIVED

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BUREAU V 6

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10609

Reg. Dist. No.

40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

3. (a) FULL NAME

DAVID L. COLLINS

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6. (b) Name of husband or wife MARY STAUP

7. Birth date of deceased (mo., day, yr.) MAY 20, 1884 / 1884 years

8. AGE:	Years	Months	Days	It less than one day
	62	5	15	hrs. min.

9. Birthplace PENNA.

(Town, County, and state)

10. Usual occupation NONE - Retired

11. Industry or business STONE MASON

12. Name ISAIAH COLLINS

13. Birthplace PENNA.

14. Maiden name LYDIA BOYD

15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL

CUMBERLAND, MD.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Nov. 8, 1946
(month) (day) (year)

Cemetery or crematory Ohio City Cem.

Location Ohio City, Penna.

18. Funeral director Kumpf's Funeral Home

Address Confluence, Penna.

19. Nov. 6, 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State PENNA. County FAYETTE

City or town OHIO PYLE
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 5, 1946 at 7:05 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from NOV. 3, 1946 to NOV. 5, 1946

and that I last saw him alive on NOV. 5, 1946

Immediate cause of death

myocardial degeneration
arteriosclerosis

DURATION

Due to

Due to

Other conditions chronic nephritis with hypertension
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

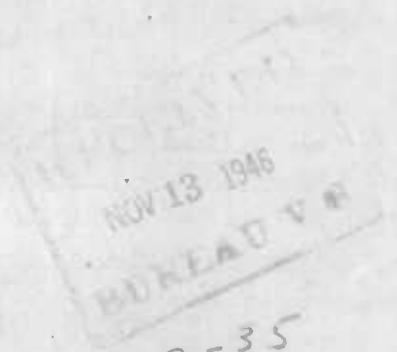
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Howard Tolson, M.D.
M. D. or other
Address Cumberland, Md. Date signed 11-5-46



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-6

10610

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... Allegany
City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
Hospital, institution, or street address where death occurred:
515 Fort Ave.

How long in hospital or institution?.....

3. (a) FULL NAME

Lawson C. Collins

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

8.(b) Name of husband or wife..... Francis Garland Collins

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1867

8.(c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
78	10	23	hrs. min.

9. Birthplace..... Artemas, Pa.
(Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business..... Farmer

12. Name..... Wesley Collins

13. Birthplace..... Penna.

14. Maiden name..... Amanda Toole

15. Birthplace..... Penna.

16. Informant..... McCormick Collins

Address 158 Polk St. Cumberland, Md.

17. Burial Date thereof Nov. 17, 1946
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Mt. Hope Cemetery

Location..... Near Artemas, Pa.

18. Funeral director..... Charles L. George

Address Cumberland, Md.

19. Nov. 17, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No..... 515 Fort Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 15, 1946, at 7:43 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27 to Nov. 14, 1946, and that I last saw him alive on Nov. 14, 1946.

Immediate cause of death..... Gastric hemorrhage.

DURATION

?

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... James E. Lee, M.D.

M. D. or other

Address..... 49 Greene St. Date signed 11-15-46

RECEIVED

NOV 26 1946

ST. MARY'S 3)

2-35

Within corporate limits

Dr. Topper

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

10611

Reg. Dist. No.

40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? no years

Hospital, Institution, or street address where death occurred:

708 Yale St.

How long in hospital or institution?

3. (a) FULL NAME

Monroe T. Conrad

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Laura Grace Hinds

7. Birth date of deceased (mo., day, yr.) September 5, 1892

6.(c) If alive, give age 50 years

8. AGE: Year 54 Month 1 Days 26 If less than one day hrs. min.

9. Birthplace Lucketts Virginia

(Town, county, and state)

10. Usual occupation Car repairman

11. Industry or business B & O R.R.

12. Name David Conrad

13. Birthplace Richmond, Va.

14. Maiden name Anna Galatt

15. Birthplace Virginia

16. Informant Mrs. Laura G. Conrad

Address 708 Yale St.

17. Burial Date thereof November 4, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory St. Peter & Paul's Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hobbs

Address Cumberland Hospital

19. Date rec'd by registrar Nov. 3 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 708 Yale St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

705 05 5200

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1946 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jas 1845 to Nov 1 1946

and that I last saw him alive on Oct 31, 1946

Immediate cause of death

Scirrhus Carcinoma
Stomach

DURATION

5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations Scirrhus Carcinoma
Stomach Date of op. July 26, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

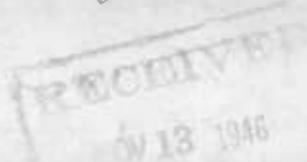
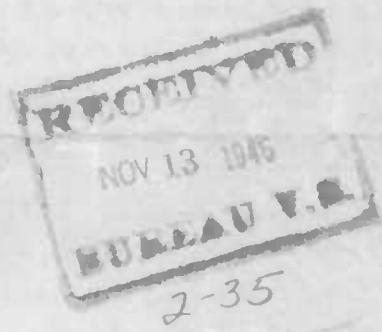
Means of injury Injured at work?

23. SIGNATURE

John G. Topper M.D.

M. D. or other

Address Hyndman, Jr. Date signed 11-2-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124-2

CERTIFICATE OF DEATH

10612

Reg. Dist. No. 4

1. PLACE OF DEATH:

ALLEGANY

County

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

19 DAYS

3. (a) FULL NAME

MRS. MAYME COZAD

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALE

WHITE

MARRIED

6.(b) Name of husband or wife

SAMUEL COZAD

7. Birth date of deceased (mo., day, yr.)

MAY 8, 1894

6.(c) If alive, give age 61 years

8. AGE:

Years
52Months
6Days
9

It less than one day

hrs. min.

9. Birthplace

PENNSYLVANIA (Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

Albert SMITH

12. Name

WEST VIRGINIA

13. Birthplace

Pa

14. Maiden name

MARY, BANKER

PENNSYLVANIA

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Nov. 10, 1946

(month) (day) (year)

Cemetery or crematory

Hill Crest Cem.

Location

Cumberland, Md.

18. Funeral director

Louis Stein Inc.

Address

Cumberland, Md.

19. (Date rec'd by registrar)

1946

J. P. Franklin, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 317 MARYLAND AVE.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 17

1946, at 12:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10....., to....., 19.....

and that I last saw him alive on.....

Immediate cause of death Degeneration of Liver.

DURATION

Due to....Alcoholism Chronic

Due to.....

Other conditions....Icterus severe

(Include pregnancy within 3 months of death)

Major findings of operations....Hepatomegaly with complete fatty degeneration, Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

Means of injury

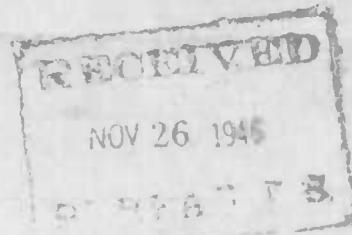
Injured at work?

23. SIGNATURE

Fuller B. Whitworth
M. D. or other

Address 1/2 Bedford St.

Date signed 19 Nov 46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 100119

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: miners' hospital

How long in hospital or institution? 3 days

3. (a) FULL NAME

George Davis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Mary Jones

7. Birth date of deceased (mo., day, yr.) Nov 21, 1863

6. (c) If alive, give age 82 years

8. AGE: Years Months Days If less than one day

83

7

24

hrs. min.

9. Birthplace Irvin Scotland

(Town, county, and state)

10. Usual occupation Coal Miner Retired

11. Industry or business Jenkins Coal Co.

12. Name William Davis

13. Birthplace Irvin, Scotland

14. Maiden name Mary Anne

15. Birthplace Irvin Scotland

16. Informant Mrs. Mary Neat

Address Frostburg, Md. R.F.D. 1-Bx 48

17. Burial Date thereof Nov. 19, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md. 1

18. Funeral director Mr. Eichhorn

Address Lonaconing, Md

19. (Date rec'd by registrar) 11-12-47 1946 Mrs. Davis & Ross

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg-R.F.D. 1-Bx 48

(If outside city or town limits, write RURAL and give nearest town)

Street No. Brights Crossing

(If rural, give LOCATION)

2.(a) If veteran, name war (None)

3. (b) Social Security Number

220-10-0977

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1946 at 6 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 13 1946 to Nov 13 1946

and that I last saw him alive on Nov 14 1946

Immediate cause of death Cerebral Hemorrhage

RT Temp Leg a

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

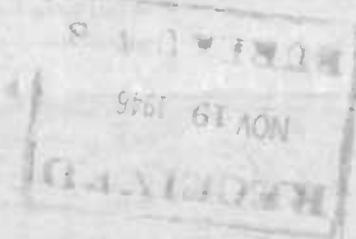
Means of injury Injured at work?

23. SIGNATURE Worm Lane Jr. M. D. or other

Address Frostburg, Md. Date signed 11-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

- 5 -



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

16014

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

Allegany

County.

Barton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Edward Deniker

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife..... Mary Mowbray

Deniker

6. (c) If alive, give age..... 32 years

7. Birth date of deceased (mo., day, yr.)

XXXXXX April 4, 1910

8. AGE: Years Months Days If less than one day
36 7 20 hrs. min.9. Birthplace..... Meyersdale - Somerset - Penna.
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business W. Va. Pulp and Paper Co.

William E. Deniker

12. Name.....

Pennsylvania

13. Birthplace..... Pennsylvania

Arla Bowser

14. Maiden name..... Pennsylvania

Mrs. Mary Mowbray Deniker

15. Birthplace..... Pennsylvania

Barton, Maryland

16. Informant.....

Laurel Hill Cemetery

Cemetery or crematory.....

Moscow, Maryland

Location.....

Ellsworth S., Roal

18. Funeral director.....

Address 111 Church St., Westernport, Md.

Nov. 26 1946

(Date rec'd by registrar)

Signature of registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Barton (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

216-05-2937

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 24 1946 at A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead Nov 24 1946

Immediate cause of death.....

Coronary occlusion

DURATION

at once

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Nature of injury..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE..... W. V. Denker M.D.

M. D. or other

Address Cumberland Md. Date signed 11/24/46



Outside of
City Limits

M
The correct age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

I

II

III

IV

V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

10615

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County

Allegany

City or town

Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

16 Months

Hospital, institution, or street address where death occurred:

Rt # 1a

How long in hospital or institution?

3. (a) FULL NAME

Hannah Dever

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Aaron Dever

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.)

October 26 1880

8. AGE:

Years

66

Months

0

Days

If less than one day

10 hrs.

min.

9. Birthplace

Pennelton Co., West Virginia

(Town, county, and state)

10. Usual occupation

House Duty

11. Industry or business

Own House

MOTHER FATHER

12. Name

Samuel L. Kimble

13. Birthplace

Pennelton Co., W. Va.

14. Maiden name

Elizabeth Westfall

15. Birthplace

Pennelton Co., W. Va.

16. Informant

Lester Dever

Address R.F.D # 3, Keyser, W. Va.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 11/9/46

(month) (day) (year)

Cemetery or crematory

Hill Crest Cemetery

Location

Cumberland, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19. Date rec'd by registrar

Nov. 8 1946

J. P. Franklin M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Allegany

City or town Near Cumberland

Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Rt # 1,

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1946 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 5 1946 to Nov 4 1946

and that I last saw her alive on Nov 4 1946

Immediately cause of death

Pulmonary Tuberculosis

Due to Cardio Renal

DURATION

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Basley Snyder M.D. M. D. or other

Address Cumberland, Md. Date signed 11/6/46

1 - 35

Within corporate limits
R. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10616

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County All AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

45 yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 35 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County All AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 748 Washington Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

3. (a) FULL NAME

Albert Doub

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife Anna Cochran Doub

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

April 11, 1865

8. AGE:

Years

Months

Days

If less than one day

81

7

3

hrs.

min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Retired Judge

11. Industry or business

12. Name Doub, Phillip13. Birthplace Maryland14. Maiden name Shutmer, Cornelia15. Birthplace Maryland16. Informant Memorial HospitalAddress Cumberland, Maryland17. Burial Rose Hill Cem.
(Burial, cremation, or removal. Which?) Date thereof Nov. 15, 1946
(month) (day) (year)Crematory or cemetery Rose Hill Cem.Location Cumberland, Md.18. Funeral director Louis Stein Inc.Address Cumberland, Md.19. Nov. 15, 1946 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14

1946, at 3:05p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 15 1946 to Nov 14 1946
and that I last saw him alive on Nov 14 1946

Immediate cause of death

Chronic MyocarditisXerophthalmia of ageArteriosclerosis

DURATION

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, asphyxia, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

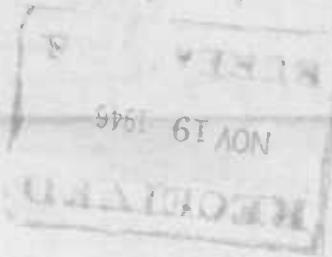
Means of injury

Injured at work?

23. SIGNATURE

J.P. Franklin, M.D. M.D. or other

Address Cumberland, Md. Date signed Nov 14/46



Within corporate limits

Elizabeth Brings

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Md.*

CERTIFICATE OF DEATH

10617

Reg. Dist. No.

40

1. PLACE OF DEATH:

County *Allegany*City or town *Cumberland*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *78 years*Hospital, institution, or street address where death occurred: *Memorial Hospital*How long in hospital or institution? *2 days*

3. (a) FULL NAME

Anna Elizabeth Dreyer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*F**W**Married*6. (b) Name of husband or wife *John G. Dreyer*

7. Birth date of deceased (mo., day, yr.)

*January 25, 1868*6. (c) If alive, give age *82* years

8. AGE:

Years *78*Months *9*Days *12*

If less than one day

hrs. min.

9. Birthplace

Cumberland, Allegany, Md.

(Town, county, and state)

10. Usual occupation *Housewife*11. Industry or business *Own home*

MOTHER FATHER

12. Name *Nicholas Schade*

13. Birthplace

*Germany*14. Maiden name *Martha Winthrop*

15. Birthplace

*Germany*16. Informant *Mrs. C. W. Fuller*

Address

Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *November 9, 1946*
(month) (day) (year)Cemetery or crematory *Greenmount Cemetery*

Location

Cumberland, Md.

18. Funeral director

John J. Hoban

Address

Cumberland, Md.

19. Nov. 8

19. 46

J. P. Franklin, M.D.

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *Allegany*City or town *Cumberland*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *450*

No. Centre St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 7, 1946, at 11:50 A.M.*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

*April 44 to Nov. 7, 1946.*and that I last saw her alive on *November 6, 1946.*

Immediate cause of death

Coronary occlusion

DURATION

Due to

Due to

Other conditions

Percutaneous balloon

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

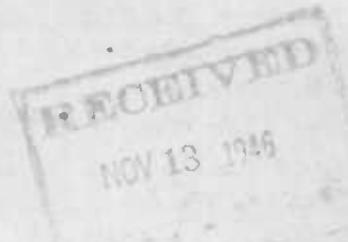
Injured at work?

23. SIGNATURE

M. D. or other

Address

*Elizabeth Brings, M.D.
Lynn, Md.*Date signed *11/8/46*



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10618

Reg. Dist. No. 60

1. PLACE OF DEATH:

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, institution, or street address where death occurred:

121 Johnson St

How long in hospital or institution?

3. (a) FULL NAME

Sophie May Duckett

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Wm. Graham Duckett

7. Birth date of deceased (mo., day, yr.) January 10, 1881

8. AGE: Years Months Days If less than one day
65 10 hrs. min.9. Birthplace Baltimore, Md
(Town, county, and state)10. Usual occupation House-wife
own home

11. Industry or business Eliza Jones

12. Name Eliza Jones
13. Birthplace Baltimore, Md14. Maiden name Caroline Elder
Germany

15. Birthplace Germany

16. Informant Mr. L. E. Jones, Sr.

Address 7101 York Rd. Towson, Md

17. Burial Date thereof Nov. 12, 1946
(Burial, cremation, or removal. Which?)

Cemetery or crematory Govans Presbyterian Cem.

Location Baltimore, Md.

18. Funeral director W. Harold Fullorh.

Address Piedmont, W. Va.

19. Nov. 10 1946 Registrar

• (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 121 Johnson St

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1946 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10 1946 to Nov. 10 1946

and that I last saw h. m. alive on Nov. 10 1946

Immediate cause of death

Acute myocardial failure

DURATION 7 hr

Due to Chronic myocarditis

Due to

Other condition Acute Pulmonary edema

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

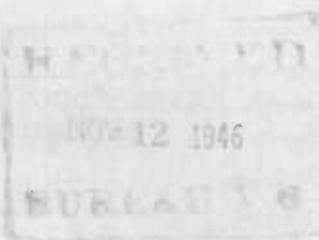
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Norman Reeves, M.D. M.D. or other
Address Westernport, Md. Date signed 11-10-46

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 40

★16619
40

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County.....*Allegany*City or town.....*Clarendon*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

45 Canal St

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Victoria Eaton

3. (b) Social Security Number

None

4. Sex

5. Color or race

6. (c) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife.....*Chas F Eaton*

7. Birth date of deceased (mo., day, yr.)

(c) If alive, give age..... years

Nov 18 1873

8. AGE:

Years

Months

Days

If less than one day

72 11 22 hrs. min.

9. Birthplace.....

(Town, county, and state)

Ind

10. Usual occupation.....

Housewife

11. Industry or business

12. Name.....*John Courtney*

13. Birthplace.....

14. Maiden name.....*Unknown*

15. Birthplace.....

16. Informant.....*Mrs Clarence Murray*Address.....*Ridgley St. Va.*17. Burial..... Date thereof.....*11-12-46*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....*Sts Peter & Paul Cem.*Location.....*Clarendon Ind.*18. Funeral director.....*Lewis Atkin Jr.*Address.....*Clarendon Ind.*

19. Nov. 11 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Allegany*City or town.....*Clarendon*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....*45 Canal St*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 10 1946

19 46 at 125 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/6 1946 to *11/10 1946*and that I last saw her alive on *11/10 1946*

Immediate cause of death.....

angina pectoris heart failure

DURATION

Due to.....*heart*

Due to.....

Other conditions.....*bronchopneumonia*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

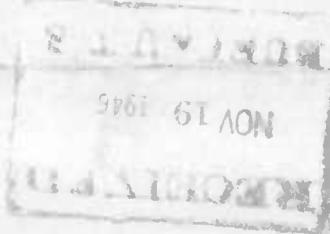
Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....*Elizabeth Brown, M.D.* Date signed *11/11/46*

2-31



DR. GROVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5-2

11448

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

3. (a) FULL NAME

MISS PAULINE FRENZEL

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALE

WHITE

SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) MAR. 23, 1880

6.(c) If alive, give age

years

8. AGE: Years Months Days If less than one day

66 7 18 hrs. min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

HOUSEWORK

11. Industry or business

12. Name FRENZEL, HENRY

13. Birthplace MARYLAND

14. Maiden name WILHELMINA SHUHART

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof Nov 14, 1946
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Morrison Cem.

Location Reynolds, Maryland

18. Funeral director Ellicsworth P. Baal
Address Westergreen, Md.19. Nov 11, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 11, 1946, at 7:15 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

NOV. 10, 1946, to NOV. 11, 1946,

and that I last saw her alive on NOV. 11, 1946.

Immediate cause of death

Turn or of the right kidney?

Due to malignant tumor of kidney, cancer.

Due to Turn or of the right kidney, 1 day.

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results Turn or of the right kidney

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Data of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)?

Means of injury

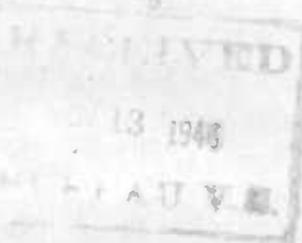
Injured at work?

23. SIGNATURE D. S. Grove, M.D.

M. D. or other

Address Michael Alday Date signed Nov 11, 1946





1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

CERTIFICATE OF DEATH

Reg. Dlat. No. 11
6621

1. PLACE OF DEATH:

County.....

City or town.....

Allegany
Little Orleans (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 yr.

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

Sarah Ellen Garland

3. (b) Social Security Number _____

4. Sex

7

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Thymaez R. Garland
(deceased)

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Feb. 6, 1860

8. AGE:

Years
86Months
9Days
23If less than one day
hrs. min.

9. Birthplace

Fulton Co. Pa.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

MOTHER

FATHER

12. Name

William Bishop

13. Birthplace

Fulton Co. Pa.

14. Maiden name

Dusan Garland

15. Birthplace

Fulton Co. Pa.

16. Informant

Alice Boden

Address

Little Orleans, Md.

Burial

Date thereof Dec 1, 1946
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

Fairview Cemetery

Location

Bedford Co. Pa.

18. Funeral director

Sphraim Smith

Address

Artemes, Pa.

19. Nov 29 1946 T. Mann per M.E. May
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Washington

City or town.....

Hancock

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

R 7 d 1

(If rural, give LOCATION)

2.(a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 29, 1946, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 24, 1946, to Nov. 29, 1946,

and that I last saw her alive on Nov. 28, 1946.

Immediate cause of death

Bronch pneumonia

DURATION

2 days

Due to

'Gripe'

1 week

Duo to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

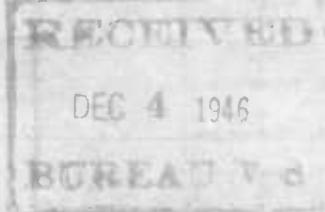
Injured at work?

23. SIGNATURE

J. A. Watson, M.D.

M. D. or other

Address Little Orleans, Md. Date signed Nov 29, 1946



1-25-

2-10 — 1-10

Within corporate limits

Jacobson.

markwood

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-6

10023

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 6 Hours

3. (a) FULL NAME

Garlitz, Dora Mrs.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

Garlitz, James E.

7. Birth date of deceased (mo., day, yr.)

May 28, 1899

6. (c) If alive, give age 60

years

8. AGE:

Years

Months

Days

If less than one day

47

5

16

hrs.

min.

9. Birthplace West Virginia

(Town, county, and state)

10. Usual occupation Housewife

&

11. Industry or business (Life Insurance Agent)

12. Name Fortney, Buckner

13. Birthplace West Virginia

14. Maiden name Mollie Rogers

15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial

Date thereof 11/17/1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory XXX Queens Point

Location Keyser, W. Va.

18. Funeral director

Address

19. Nov. 17 1946 Joseph (Frank) M. Jacobson

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Mineral

City or town Keyser

(If outside city or town limits, write RURAL and give nearest town)

Street No. 281 Fort Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

234-40-2985

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1946

at 9:55pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 14 1946 to Nov. 14 1946

and that I last saw her alive on Nov. 14 1946

Immediate cause of death

Myocardia Failure

DURATION

Due to

Myocardia Failure

?

Due to

Atrial fibrillation

?

Due to

Cerebral hemorrhage

?

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. M. Jacobson M. D. or other

Address 15 Liberty St. Date signed 11/15/46

RECEIVED

NOV 26 1946

BUREAU OF E.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 106-2

CERTIFICATE OF DEATH

★ 10622

Reg. Dist. No. 9

1. PLACE OF DEATH:

County.....

Allegany of Frostburg

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

80 C Mechanic St.

How long in hospital or institution?

3. (a) FULL NAME

Patrick Lee Garsity

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age ✓ years

October 18, 1946

8. AGE:

Years

Months

Days

If less than one day

1

12

hrs.

min.

9. Birthplace.....

Leesburg, Alleg. Md.

(Town, county, and state)

10. Usual occupation.....

Child

11. Industry or business

Patrick Garrett Garsity

MOTHER FATHER

12. Name.....

13. Birthplace

Frostburg, Md.

14. Maiden name.....

15. Birthplace

Myrtle Ann McKenzie

Cumberland, Md.

16. Informant.....

Address

Mr. Patrick Garsity

Frostburg, Md.

17. Burial

(Burial, cremation, or removal, if any)

Date thereof 12-2-1946

(month) (day) (year)

Cemetery or crematory

St. James Cemetery

Location.....

Frostburg, Md.

18. Funeral director.....

Address

Wm. W. Cuttler

Graetersville, Md.

19. 11-30

(Data rec'd by registrar)

19 46 Mr. Harry A. Rose

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Garrett

City or town.....

Frostburg, Md.

Street No.....

Rural

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH November 30 1946 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 30 1946 to November 30 1946

and that I last saw him alive on November 30 1946

Immediate cause of death.....

acute bronchitis

DURATION

100

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

H. C. Siehl, M.D.

M. D. or other

Address Frostburg, Md. Date signed 11-30-46

RECEIVED

DEC 3 1946

BUREAU V.B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 112

10024

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County.....

City or town.....

Allegany
Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Mines Hospital

How long in hospital or institution?.....

3 months

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M**W**married*

8. (b) Name of husband or wife.....

Annie Greening

7. Birth date of deceased (mo., day, yr.)

Dec. 7, 1887

6. (c) If alive, give age..... years

8. AGE:

Years 59	Months 11	Days 9	Hours 11 less than one day	min.
-------------	--------------	-----------	-------------------------------	------

9. Birthplace.....

(Town, county, and state)
St. Marys

10. Usual occupation.....

Miner

11. Industry or business

coal

MOTHER

FATHER

12. Name.....

Paul John Greening

13. Birthplace.....

St. Marys

14. Maiden name.....

Maria Jones

15. Birthplace.....

St. Marys

16. Informant.....

Raymond Greening

Address

Frostburg, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....
(month) (day) (year)
Dec. 1-1946

Cemetery or cemetery

allegany

Location.....

Frostburg, Md.

18. Funeral director.....

J. F. Deeney

Address

Frostburg

19. Date rec'd by registrar

11-30

1946 Mrs. Dailey M. Rae

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

M.D. County.....
allegany

Street No.....

City or town.....

3 Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.....

City or town.....

101 Walnut (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

213-10-9712

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

Nov 28 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 26 1946 to *Nov 28* 1946 and that I last saw him alive on *Nov 28* 1946

Immediate cause of death.....

acute cardiac
decompensation

DURATION

Due to.....

Bronchial asthma *several years*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

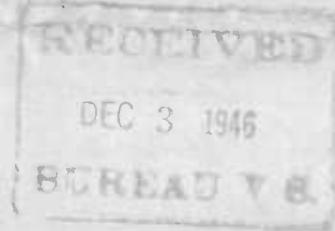
Injured at home, farm, industry, public place (where?).....

Meane of injury.....

Injured at work?

23. SIGNATURE

John McFayen Jr. M. D. or otherAddress..... *Frostburg, Md.* Date signed *11-29-46*



1-35

D. Trenaskis, S.R.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10625

CERTIFICATE OF DEATH

Reg. Dist. No. 40

X correct age

1. PLACE OF DEATH:

County

Allegany
Cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 years

Hospital, Institution, or street address where death occurred:

131 Grand Avenue

How long in hospital or institution?

3. (a) FULL NAME

James Anthony Gross

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

Widowed

6. (b) Name of husband or wife

Gross

Mary Ann "Goldizen"

7. Birth date of deceased (mo., day, yr.)

April 17, 1857

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Morgan Co., W. Va.

(Town, county, and state)

10. Usual occupation

Retired Railroad Conductor

11. Industry or business

B. & O. Railroad

12. Name

Henry Gross

13. Birthplace

Unknown

14. Maiden name

Mary Gates

15. Birthplace

Unknown

16. Informant

George W. Gross

Address

134 Arch St. Cumberland, Maryland

17. Burial

Date thereof November 21, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Maryland

18. Funeral director

John J. Wafer

Address

Cumberland, Maryland

19. Nov. 22, 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

131

Grand

Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 20

19

46

21. I CERTIFY that death occurred on the date above stated that deceased from

Jan 1

19

46

and that I last saw deceased on

Nov 18

19

46

Immediate cause of death

Chronic myocarditis

DURATION

2 yrs

Due to

Due to

Other conditions

Arteriosclerosis

2 yrs

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

P. J. Trenaskis, Jr., M.D.

M. D. or other

Address

Cumberland, Md.

Date signed

RECEIVED

NOV 26 1946

LIBRARY

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Kights

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

10626

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 1 Day

3. (a) FULL NAME

Hamilton, Frank M.

4. Sex Male Color or race White 5. (a) Single, married, widowed, or divorced Single

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) September 22, 76. 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
70 1 21 hrs. min.9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Charles M. Hamilton

13. Birthplace West Virginia

14. Maiden name Elizabeth Ashkettle

15. Birthplace Maryland

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial

(Burial, cremation, or removal. Which?) Date thereof 11/16/46

(month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18. Funeral director William H Kight

Address Cumberland, Md.

19. Nov. 15 1946
(Date rec'd by registrar)J. P. Franklin, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No North Branch

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1946, at 9:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from nov. 11, 1946, to nov. 13, 1946, and that I last saw him alive on nov. 13, 1946.

Immediate cause of death Generalized Arteriosclerosis
Myocarditis 5 yrs. DURATION

Due to Generalized Arteriosclerosis - 6 yrs.

Date of

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

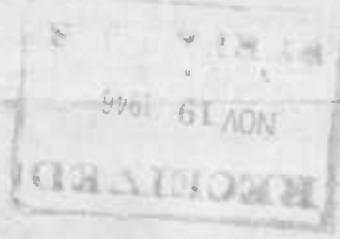
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Franklin, M.D.
Cumberland, Md. Date signed 11/13/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1220

10627

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

3 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 3 days

3. (a) FULL NAME

Katie Tenia Harclerode

4. Sex

Fe

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb. 1 1879

6.(c) If alive, give age years

8. AGE: Years

67

Months

9

Days

16

If less than one day

hrs.

min.

9. Birthplace

Hyndman, Pa.

(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

Jonathan Harclerode

MOTHER FATHER

12. Name

Pa.

13. Birthplace

Pa.

14. Maiden name

Annie Miller

15. Birthplace

Pa.

16. Informant

Charles Harclerode

Hyndman, Pa.

Address

17. Burial

Date thereof nov. 20, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hyndman, Pa.

Location

Hyndman, Pa.

18. Funeral director

Harvey H. Zeigler

Address

Hyndman, Pa.

19. Date rec'd by registrar

19 46

(Date rec'd by registrar)

John A. Capper M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County Bedford

City or town Hyndman, Pa.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 17

19 46 at 7PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15

19 46

to Nov. 17 19 46

and that I last saw her alive on Nov. 17 19 46

Immediate cause of death

Submarginal embolus

1 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Strangulation ulcer

Date of op. Nov. 16, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John A. Capper M.D.

M. D. or other

Address

Hyndman, Pa.

Date signed Nov. 17, 1946

58-6

~~BUREAU OF INVESTIGATION~~

NOV 26 1946

3

70th day of my
3, lost my

1
Whisker

so fun!

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 668

CERTIFICATE OF DEATH

Reg. Dist. No. 40

Coll Haffey
10628
white sign
40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

12 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

12 days

How long in hospital or institution?

3. (a) FULL NAME

HARPER, RAYMOND ASHLEY As66ee

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

W

SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 9 1944

8. AGE:

Years

Months

Days

If less than one day

2

1

16

hrs.

min.

9. Birthplace MARYLAND

(Town, county, and state)

10. Usual occupation INFANT

11. Industry or business

12. Name HARPER, HARLON A.

13. Birthplace W. VA.

14. Maiden name DICKEN, CLEONA

15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof November 28, 1946
(month) (day) (year)

Cemetery or crematory Teter Cemetery

Location Bowman's Addt., Cumberland, Md.

18. Funeral director

John F. Stofie

Address Cumberland, Maryland

Nov. 27, 1946

(Date rec'd by registrar)

DR. C.L. OWENS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD.

County

ALLEGANY

City or town

CUMBERLAND

Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

RFD #3, VALLEY ROAD

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 25

19

46

at

5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 13th 1946 to Nov 25th 1946and that I last saw him alive on Nov 25th 1946

Immediate cause of death

Harold Belcher - Blusthan

Syndrome

Due to

Due to

Other conditions

Anemia Severe

3 months

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op. 11-26-46

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

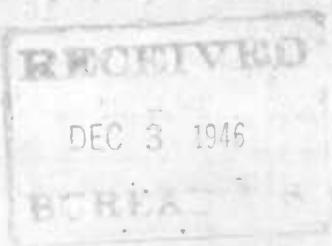
Means of Injury

Injured at work?

23. SIGNATURE

P/L Owens M.D. M. D. or other

Address Cumberland, Md. Date signed 11-26-46



I-35

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

DR. ELIASON

10629

Reg. Dist. No. 40

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

3. (a) FULL NAME

632
HELEN LOUISE HARTSOCK

4. Sex

5. Color or race

FEMALE

WHITE

6.(a) Single, married, widowed, or divorced

SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

JULY 17, 1946

8. AGE: Years

Months

Days

If less than one day

3

14

hrs.

min.

9. Birthplace CUMBERLAND, MD.

(Town, county, and state)

10. Usual occupation

INFANT

11. Industry or business

ROBERT HARTSOCK

MOTHER FATHER

12. Name DOROTHY McELFISH

MOTHER MOTHER

MARYLAND

14. Maiden name DOROTHY McELFISH

15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL

CUMBERLAND, MD.

Address

Burial

Date thereof November 21, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory Prosperity Christian Cemetery

Location R.F.D. 1, Flintstone, Md.

18. Funeral director

John J. Hoban

Address Cumberland, Md.

19. Nov. 2, 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ALLEGANY

City or town FLINTSTONE

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 1

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 31, 1946, to Oct 31, 1946,

and that I last saw her alive on Oct 31, 1946.

Immediate cause of death

Motor pneumonia

DURATION

10 days

Due to

Due to

Other condition

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

DR. ELIASON

M.D. or other

Address 234 Mount Cumberland Rd. Date signed 11/16/46



1-35-

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170

CERTIFICATE OF DEATH

106304

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... About 7 hours

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?..... About 7 hours

3. (a) FULL NAME

Riley D. Heavner

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male white

Single

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Sept. 12. 1924

8. AGE:

Years

Months

Days

If less than one day

22 2 17 hrs. min.

9. Birthplace.....

Pittsburg W. Va.

(Town, County, and state)

10. Usual occupation.....

H. S. Fire Co.

11. Industry or business

FATHER

12. Name..... Branson A. Heavner

W. Va.

13. Birthplace

MOTHER

14. Maiden name..... Ethel Goldizer

W. Va.

15. Birthplace

16. Informant.....

Branson A. Heavner

Address

Gilberton, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Dec 2 46

(month) (day) (year)

Cemetery or crematory.....

Wilcox Cem.

Location.....

Cumberland

18. Funeral director.....

Louis Stein Joe

Address

Cumberland

19. Now 30 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Allegany

City or town..... Flintstone Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... R.F.D.2

(If rural, give LOCATION)

2.(a) If veteran, name war..... II World War.

3. (b) Social Security Number

736-20-9434

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 29

19. at 2.05A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on Nov. 29

19. 46

Immediate cause of death.....

Pulmonary Hemorrhage

DURATION

Due to punctured lung from
fractured ribs

about 7

hours

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Auto. Accident date of 11.28.46

near Cumberland Allegany Md.

Where did injury occur?.....

(City or town) (County) (State)

3 1/2 miles East of Cumberland Md.

Injured at home, farm, industry, public place (where?) Route 40

Means of injury Auto. collision Injured at work? no

Deputy Medical Examiner Allegany Co.

23. SIGNATURE..... H. V. Denning Md.

M. D. or other

Address..... Cumberland Md. Date signed 11/29/46

RECEIVED

DEC 3 1946

BUREAU F B I

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10631

DR. GRACIE & OWENS

CERTIFICATE OF DEATH

Reg. Dist. No. 40

Exact age
I ne coet age

Supply every item of information carefully. Please write the causes of death clearly and legibly.

especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 12 DAYS

3. (a) FULL NAME

MRS. EDITH HETTENHouser

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife JOHN L. HETTENHouser

7. Birth date of deceased (mo., day, yr.) FEBRUARY 2, 1892

8. AGE: Years Months Days If less than one day
54 9 2 hrs. min.9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name McCUSKER, JOHN

13. Birthplace MARYLAND

14. Maiden name BARNHART, NAN

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. BURIAL Date thereof NOV. 7, 1946
(Burial, cremation, or removal. Which?)

Cemetery or crematory ST. PATRICK'S CATHOLIC

Location LITTLE ORLEANS, MD.

18. Funeral director CHARLES R. BAST

Address HANCOCK, MD.

Nov. 5, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LITTLE ORLEANS

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name was

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 4 1946 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to 1946

and that I last saw her alive on Nov. 4 1946

Immediate cause of death Fulcrum on my duotube

Due to Adrenaline injection

& Gerovital injection

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Adrenaline injection & relaxed Date of op. Oct 24-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.G. Gracie M. D. or other

Address Cessna Date signed Nov 4-46

(Date rec'd by registrar) Registrar Date signed Nov 4-46

RECEIVED
NOV 13 1946
FBI - BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10032

Reg. Dist. No. 100

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

Alleghany

Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

44 years

Hospital, institution, or street address where death occurred:

Mt. Savage

How long in hospital or institution?

3. (a) FULL NAME

Annie Nichols Hatchkiss

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White

Married

6. (b) Name of husband or wife

Richard C. Hatchkiss

7. Birth date of deceased (mo., day, yr.)

May 19, 1882

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

64

5

23

hrs.

min.

9. Birthplace

(Town, county, and state)

Evanescing, Allegany Co., Md.

Horsefly Brook

10. Usual occupation

Horsefly Brook

Own home

11. Industry or business

None

12. Name

Benjamin F. Nichols

13. Birthplace

Pennsylvania

14. Maiden name

Sarah McGee

15. Birthplace

Scotland

16. Informant

Richard C. Hatchkiss

Address

Mt. Savage, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

Nov. 13

(Date rec'd by registrar)

19. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No. Boundary Row

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12th 46, 5:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19, 1946, to Nov. 12th, 1946,and that I last saw her alive on November 12th, 1946.

Immediate cause of death

Cerebral Hemorrhage

Due to

Cardiac Hypertension.

Other conditions Chronic Myocarditis & Nephritis -

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Mosley, M.D.

M.D. or other M. D. or other

Address Mt. Savage, Md. Date signed 11-13-46

RECEIVED

NOV 16 1946

BUREAU V

1-81-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

100930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

9-45-1

V8 A15

1. PLACE OF DEATH:

County.....

Allegany

City or town.....

Frederick, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

William James Hughes

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

married

6. (b) Name of husband or wife.....

Sergeant Fred

7. Birth date of deceased (mo., day, yr.)

Aug. 16th. 1895

B. (c) If alive, give age.....

years

8. AGE:

Years

Months

Days

If less than one day

51

2

19

mrs.

min.

9. Birthplace.....

Frederick, Md

(Town, county, and state)

10. Usual occupation.....

Custodian

11. Industry or business.....

Mill St. School

12. Name.....

James J. Hughes

13. Birthplace.....

Frederick

14. Maiden name.....

R. Fife

15. Birthplace.....

England

16. Informant.....

John Hughes

Address.....

76 Spring St.

17. Burial (Burial, cremation, or removal. Which?)

Burial

Date thereof..... 11-8-1946

(month) (day) (year)

Cemetery or crematory.....

Allegany

Location.....

Frederick, Md

18. Funeral director.....

Sergeant Fred

Address.....

Frederick, Md

19. (Date rec'd by registrar).....

11-9

1946

W. H. Keay & Son

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Allegany

City or town.....

Frederick

County.....

Allegany

Street No.....

131

Ridge St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

219-14-5955

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Nov 5 1946 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from

18

to

19

end that I last saw him ~~in bed~~ Nov 6 1946

Immediate cause of death.....

Coronary occlusion

DURATION

at once

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

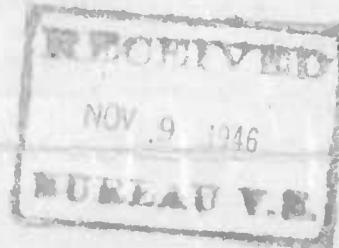
23. SIGNATURE.....

W. H. Keay 20-5

M. D. or other

Address..... Cumberland, Md Date signed 11-6-46

Deputy Medical Examiner - Allegany Co.



1-35

71

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

10634
90

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Allegany

City or town

Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 92 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Jones

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Divorced

6.(b) Name of husband or wife

Elisus A. Masterson

7. Birth date of deceased (mo., day, yr.)

Mar. 20th. 1854

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

92

7

30

9. Birthplace

Frostburg Allegany, Md

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Grocery Business

MOTHER FATHER

Name

James Jones

13. Birthplace

Wals

Currituck Co. N.C.

14. Maiden name

Curtiss

Brooks

15. Birthplace

England

Other

16. Informant

James Jones

Address 185 E. Main St. Frostburg

17. Burial, cremation, or removal. Which?

Burial

Date thereof 11-22-1946

(month)

(day)

(year)

Cemetery or crematory

Allegany

Location

Frostburg

Dad

18. Funeral director

Jacob Draper

Address

Frostburg

Md

19. 11-21

1946 Mrs. Nancy H. Roe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Allegany

City or town

Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

185 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 19 1946 at 3:01 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1946 to Nov 19 1946 and that I last saw him alive on Nov 16 1946

Immediate cause of death

Arteriosclerosis many years

DURATION

Due to

Sensitivity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Frostburg Md. date signed 11-20-46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10635

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

52 Years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

721 Greene St.

How long in hospital or institution?

3. (a) FULL NAME

John Fredrick Keifer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Eleanor Keifer

7. Birth date of deceased (mo., day, yr.)

September 2 1894

8. (c) If alive, give age 26 years

8. AGE:

Years
52Months
2Days
26

It less than one day

hrs.
.....min.
.....

9. Birthplace

Cumberland Allegany Co. Maryland

(Town, county, and state)

10. Usual occupation

Back Shops

11. Industry or business

Baltimore & Ohio Railroad

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

Katherine Keifer

15. Birthplace

Cumberland, Maryland

16. Informant

Mrs. John F. Keifer

Address

721 Greene St. Cumberland, Md.

17. Burial

Date thereof 12/2/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St Peter & Paul Cemetery

Location

Cumberland, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19. Date rec'd by registrar

1946

(Date rec'd by registrar)

J. P. Franklin Jr.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md.

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 721 Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

705-05-5198

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1946 19. 46, 11.15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to

and that I last saw him Dead Nov. 28

19. 46

Immediate cause of death

Coronary occlusion

Duration

5

minutes

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

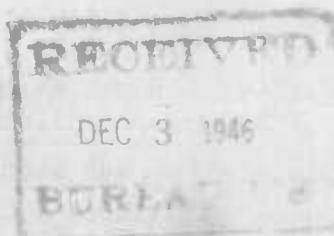
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE H.H. Dunning M.D. M. D. or other

Address Cumberland, Md. Date signed 11-29-46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 36

CERTIFICATE OF DEATH

10636 40
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Cumberland, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 7 days

3. (a) FULL NAME

Mrs. Hester Keith

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife Henry Keith

7. Birth date of deceased (mo., day, yr.) March 8, 1895
8. (c) If alive, give age 65 years

8. AGE: Years	Months	Days	If less than one day
51	8	2	hrs. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER	12. Name	Thomas Hickle
	13. Birthplace	West Virginia
MOTHER	14. Maiden name	Amanda Katherine Watts
	15. Birthplace	West Virginia

16. Informant Memorial Hospital
Address Cumberland, Maryland17. Burial Date thereof Nov. 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Zion MemorialLocation Cumberland, Md.
18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Nov. 18, 1946 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Allegany
 City or town..... Cumberland (RURAL)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... P. O. Box 193, LaVale
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1946, at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3, 1946, to Nov. 10, 1946, and that I last saw her alive on Nov. 10, 1946.

Immediate cause of death Pulmonary Embolism

Due to Hypertension for 2 weeks

Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. X Date of X

Where did injury occur? (City or town) X (County) X (State) X

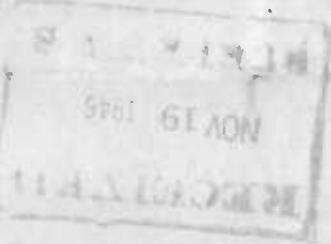
Injured at home, farm, industry, public place (where?)

Meena of Injury Injured at work?

23. SIGNATURE A.H. Hawkins

M. D. or other

Address Cumberland, Md. Date signed 11-12-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10637

CERTIFICATE OF DEATH

Reg. Dist. No.

90

1. PLACE OF DEATH:

County AlleganyCity or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs.Hospital, Institution, or street address where death occurred: Memorial HospitalHow long in hospital or institution? 2 4 hrs.

3. (a) FULL NAME

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Frances Tallups7. Birth date of deceased (mo., day, yr.) July 14 - 18978. AGE: Years 69 Months 4 Days 5 If less than one day
hrs. 0 min. 09. Birthplace Borden Colley Md.
(Town, county, and state)10. Usual occupation Petrolia11. Industry or business Coal mines12. Name Ernestine J. L. Rose13. Birthplace Giant City, Md.14. Maiden name Elizabeth B. Clegg15. Birthplace Franklin Co. Pa.16. Informant Mrs. Ernestine J. L. Rose17. Burial Date thereof 11-22-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegany CemeteryLocation Frostburg, Md.18. Funeral director Joe H. DaigleAddress Frostburg, Md.

19. 11-21 1946 Mrs. Nancy H. Roe

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County AlleganyCity or town Borden Rd. Frostburg, Md.(If outside city or town limits, write RURAL and give nearest town)
Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1946 at 3:1521. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1941 to 1946 and that I last saw h. alive on November 19 1946

Immediate cause of death

Coronary Thrombosis DURATION 4 daysDue to Arteriosclerotic heart disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

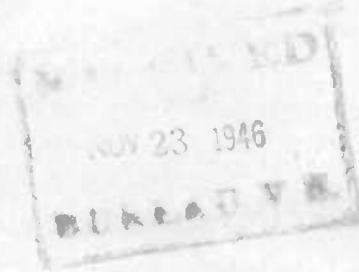
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda Faulkner M. D. or otherAddress Frostburg, Md. Date signed 11/21/46



1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-2

10638

DR. DURRETT
DR HODGES

Reg. Dist. No. 40

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

ALLEGANY

City or town

CUMBERLAND, MD.

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

3. (a) FULL NAME

BABY BOY KIMBLE (PREMATURE)

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

NOVEMBER 18, 1946 12:56 A.M.

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

5 hrs. min.

8. Birthplace

MEMORIAL HOSPITAL

(Town, county, and state)

10. Usual occupation

11. Industry or business

GLENN KIMBLE

MOTHER FATHER

12. Name

WEST VIRGINIA

13. Birthplace

Mary C. APPS

14. Maiden name

NORTH CAROLINA

15. Birthplace

Memorial Hosp.

16. Informant

Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Nov. 18

(Date rec'd by registrar)

Date thereof (month) (day) (year)

20. Nov. 18

(Date of death)

21. Nov. 18

(Date of death)

22. Nov. 18

(Date of death)

23. Nov. 18

(Date of death)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 709 MADISON STREET

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

NOVEMBER 18, 1946

5:56 A.M.

2D. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov. 18 1946 to Nov. 18 1946 and that I last saw him alive on Nov. 18 1946

Immediate cause of death

Premature
separation of placenta

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Hemorrhage in uterine wall Date of op. Nov. 18 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

DR. DURRETT DR. HODGES

CUMBERLAND, MD.

M. D. or other

CUMBERLAND, MD.

Date signed Nov. 18 1946

RECEIVED

M 26 1946

BIBLIOTEK

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

Dr. Reeves

Reg. Dist. No. 6

10639

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany

City or town..... Barton (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 75 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Francis Kyle

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widower

6.(b) Name of husband or wife..... Anna Mae Kyle

7. Birth date of deceased (mo. day, yr.) November 11, 1871

8. AGE: Years Months Days If less than one day
75 0 10 . hrs. min.9. Birthplace Barton, Allegany, Maryland
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal mine

12. Name..... Frederick Kyle

13. Birthplace Mathias, W. Va.

14. Maiden name Harriet Barnes

15. Birthplace Barton, Maryland

16. Informant Frederick Kyle

Address Barton, Maryland

17. Burial 24 Nov 1946

(Burial, cremation, or removal. Which?) Date thereof. (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location NO. 320 W. Main Street, Laurel Hill Cemetery, Maryland

18. Funeral director Ellsworth S. Boal

Address 111 Church St., Westernport, Md.

19. (Date rec'd by registrar) Nov 24 1946 Registrar M. S. Graymiller M.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Barton (rural)
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1946 at 6:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 19 1946 to Nov. 21 1946 and that I last saw h. alive on Nov. 20 1946

Immediate cause of death

Respiratory distress

DURATION

1 week

Due to: The respiratory distress

Due to: and anemia

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

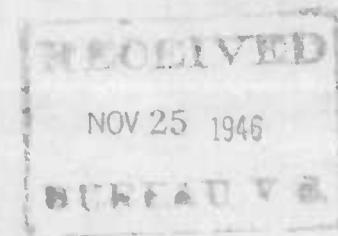
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. D. Gray, M.D.
M. D. or other
Address: Corbett Rd. Date signed: 11/24/46



1 - 35

PLEASE WRITE PLAINLY, WITH UNEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4000

18640

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 101 Days

3. (a) FULL NAME

Mary Lepley

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife Oliver Lepley

7. Birth date of deceased (mo., day, yr.) February 10, 1912 8. (c) If alive, give age 40 years

8. AGE: Years Months Days If less than one day
3 4 8 22 hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Anderson

13. Birthplace Maryland

14. Maiden name Minnie Hamilton

15. Birthplace Maryland

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof Nov. 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Nov. 5 1946 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Allegany

City or town Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Christie Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1946 at 3:18 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-12-46 to 11-2-46, and that I last saw him alive on 10-12-46.

Immediate cause of death

Carcinoma uterus

DURATION

2 yrs

Due to

Due to

Carcinomatous

6 mo

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Carcinoma cervix

Date of op.

Autopsy results

more

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

13-1945

13-1945

2-35

Within corporate limits

D DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122-B

10641

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

12 DAYS

How long in hospital or institution?

MEMORIAL HOSPITAL

3. (a) FULL NAME

MRS. BRIDGET LOGSDON

4. Sex FEMALE | 5. Color or race WHITE | 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife ALLEN LOGSDON

7. Birth date of deceased (mo., day, yr.) 6/8/1874 | 6. (c) If alive, give age years

8. AGE: Years 72 Months 5 Days 2 If less than one day hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name of MOTHER FATHER Anthony Kelly

13. Birthplace Ireland

14. Maiden name Bridget Pyle

15. Birthplace Ireland

16. Informant MEMORIAL HOSPITAL
CUMBERLAND, MARYLAND17. Burial Date thereof Nov. 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Patrick's

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Nov. 17 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

State MARYLAND | County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 COLUMBIA ST. | (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 10 1946 at 7:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT. 29 1946 to NOV. 10 1946.

and that I last saw her alive on 19.

Immediate cause of death

acute gastritis
heart following
due to myocarditisDue to myocarditis
acute intestinal
obstruction

Other conditions due to old adhesions.

Not due to cancer curable
(Include pregnancy within 3 months of death)Major findings or operations intestinal obstruction
Date of op. NOV. 1, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

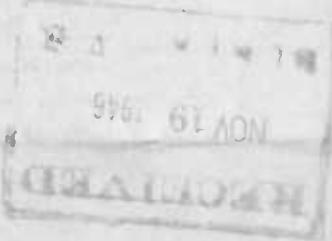
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. M. Wilson, M.D. M. D. or other

Address Cumberland, Md. Date signed 11-10-46



Outside of
City Limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. D. No. 10642

40

1. PLACE OF DEATH:

County Allegany
City or town New Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs

Hospital, institution, or street address where death occurred:

Shanks Lane & Route 40, Laclede

How long in hospital or institution?

3. (a) FULL NAME

Paul Wm Marriott

4. Sex Male Color or race White Marital status Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Rachael Miller

7. Birth date of deceased (mo., day, yr.) April 15, 1870

6. (c) If alive, give age 82 years

8. AGE: Years Months Days If less than one day
76 6 17 hrs. min.9. Birthplace Westernport Allegany Co Md
(Town, county, and state)

10. Usual occupation Retired Bookskeeper

11. Industry or business Wholesale Grocery

12. Name John Marriott

13. Birthplace Howard County Md

14. Maiden name Julia Barnett

15. Birthplace Howard County Md

16. Informant Oliver Marriott

Address Route 1 Cumberland Md

17. Burial Cemetery or crematory S.O.O.T Cemetery

(Burial, cremation, or removal. Which?) Date thereof Apr 5 1946

Cemetery or crematory (month) (day) (year)

Location Westernport Md

18. Funeral director John J. Hafer

Address Cumberland Md

19. Nov. 5 1946 J.P. Franklin, M.D.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Laclede Near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Shanks Lane & Route 40

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1946 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10/30 1946 to 11-1 1946

and that I last saw h. survive on

Immediate cause of death Cardiosclerosis

DURATION

Due to Atherosclerosis

Due to

Other conditions Parkinson's disease

Enlarged prostate

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Dr Lester

M. D. or other

Address 122 Bradford St Date signed Nov 9 1946

2-35

RECORDED
13 1946

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

CERTIFICATE OF DEATH

10643

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... ALLEGANY

City or town..... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

3. (a) FULL NAME

BABY GIRL McCULLOUGH

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) NOVEMBER 5, 1946

8. AGE: Years	Months	Days	If less than one day
		2	hrs. min.

9. Birthplace..... MARYLAND, Cumberland, Alleg. Co.
(Town, county, and state)

10. Usual occupation..... NEW BORN

11. Industry or business

MOTHER FATHER 12. Name..... McCULLOUGH, WILLIAM

13. Birthplace..... MARYLAND

14. Maiden name..... TWIGG, MARY ALICE

15. Birthplace..... MARYLAND

16. Informant..... MEMORIAL HOSPITAL

Address..... CUMBERLAND, MARYLAND

17. Cremation.....

(Burial, cremation, or removal, Which?)

Date thereof..... Nov. 8, 1946
(month) (day) (year)

Cemetery or crematory..... Memorial Hosp.

Location..... Cumberland, Md.

18. Funeral director..... Same as above

Address.....

19. Nov. 8 1946 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... ALLEGANY MD. County..... ALLEGANY

City or town..... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 810 MAPLEWOOD AVE., CITY

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... NOV. 8

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 8 1946 19 10 to Nov. 8 1946 19 46

and that I last saw her alive on Nov. 8 1946 19 46

Immediate cause of death..... Pretermaturity

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... DR. Hodges, M.D.

M. D. or other.....

Address..... Cumberland, Md.

Date signed..... Nov. 8 1946

RECORDED

MAR 13 1946

LIBRARY OF CONGRESS

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10644

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County

allegany

City or town

Forestburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

9 Charles St.

How long in hospital or institution?

3. (a) FULL NAME

Peter S. McGuire

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

widowed

6. (b) Name of husband or wife

Margaret McGuire

7. Birth date of deceased (mo., day, yr.)

nov. 15 - 1870

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

76

0

10

hrs.

min.

9. Birthplace

Boston - allegy - md.

(Town, county, and state)

10. Usual occupation

ret'd

11. Industry or business

Patrick McGuire -

FATHER

12. Name

Patrick McGuire -

13. Birthplace

Ireland

MOTHER

14. Maiden name

Ann McCrory -

15. Birthplace

Ireland -

16. Informant

Mrs George Lippman

Address

Forestburg Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof nov. 25-1946

(month) (day) (year)

Cemetery or

St Michaels

Location

Forestburg

18. Funeral director

J. P. Doherty

Address

Forestburg Md.

19. (Date rec'd by registrar)

19

46 Mr. Dauncy A. Roe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County allegany

City or town

Forestburg (If outside city or town limits, write RURAL and give nearest town)

Street No.

9 Charles Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 22 1946 25:00P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 19 1946 to Nov 22 1946 and that I last saw him alive on Nov 22 1946

Immediate cause of death

arteriosclerosis

DURATION

years

Due to

Mr. Deane

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. McGuire M. D. or other

Address Postscript signed 11-24-46

RECEIVED

NOV 27 1946

BUREAU

1-35

Within corporate limits of field

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 123

CERTIFICATE OF DEATH

10645

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 6 days

3. (a) FULL NAME

Mr. Roland O. Mease

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Vesta Gallagher

7. Birth date of deceased (mo., day, yr.) February 28, 1884

8. AGE:	Years	Months	Days	If less than one day
	62	8	12	hrs. min.

9. Birthplace Pennsylvania

(Town, county, and state)

10. Usual occupation Carpenter Foreman

11. Industry or business Baltimore & Ohio Railroad

12. Name David Mease

13. Birthplace Pennsylvania

14. Maiden name Amelia Goss

15. Birthplace Pennsylvania

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof Nov. 13, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland, Md

18. Funeral director Charles L. George

Address Cumberland, Md

19. Nov. 19 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 121 Roberts Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

705-05-1755

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1946 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw deceased on

Immediate cause of death

Cerebral hemorrhage
Resulting from
Pneumonia & Tuberculosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

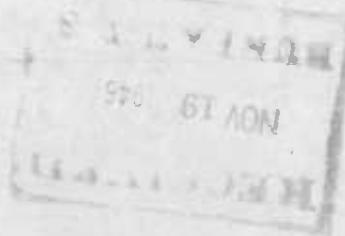
Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland, Md Date signed 11/13/46

-8-2



Within corporate limits
The connect age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

10646

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 4 Hrs.

3. (a) FULL NAME

James Vernon Mellott

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age years

May 24, 1924

8. AGE: Years Months Days If less than one day

22 5 8 hrs. min.

9. Birthplace..... Harpers Ferry, W. Va.

(Town, county, and state)

10. Usual occupation..... Brakeman

11. Industry or business..... Western Maryland R.R. Co.

12. Name..... Corder Mellott

13. Birthplace..... Buck Valley, Penna.

14. Maiden name..... Bessie Piper

15. Birthplace..... Blue Ridge, Va.

16. Informant..... Mrs. Eva Mellott

Address..... 201 1/2 Mary St. Cumberland, Md.

17. Burial Date thereof Nov. 5, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Luthern Cemetery

Location..... Harpers Ferry, W. Va.

18. Funeral director..... Charles L. George

Address..... Cumberland, Md.

19. Nov. 5 1946 J. P. Franklin M.D.

(Date rec'd by registrar) (Signature) (Title) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 201 1/2 Mary St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

218-12-5953

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 2, 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 2, 1946, to Nov. 2, 1946,

and that I last saw him alive on Nov. 2, 1946.

Immediate cause of death..... Hemorrhage in phleb

Due to..... Anger tate on 3 both eyes.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Railroad

Means of injury..... Ran over by train

Injured at work?..... Yes

23. SIGNATURE..... J. P. Franklin M.D.

M. D. or other..... Medical Field

Address.....

Date signed..... Nov. 4, 1946

RECEIVED

NOV 9 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10647

13-6

CERTIFICATE OF DEATH

Reg. Dist. No.

40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7.5 yrs

Hospital, institution, or other address where death occurred:

804 Columbia Ave.

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Jessie Verlinda Metzger

3. (b) Social Security Number

None

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

Widowed

6. (b) Name of husband or wife

Harry E. Metzger

7. Birth date of deceased (mo., day, yr.)

June 15, 1870

(c) If alive, give age years

8. AGE:

Years 76 Months 5 Days 11 It less than one day hrs. min.

9. Birthplace

Wheeling Ohio Co., W. Va.

(Town, county, and state)

10. Usual occupation

Habersworks

11. Industry or business

At Home

MOTHER FATHER

12. Name Edward J. Keller

13. Birthplace

Fort Ashby, W. Va.

14. Maiden name

Ruth E. Simpkins

15. Birthplace

Cumberland, Md.

16. Informant

E. J. Wellington Metzger

Address

804 Columbia Ave - Cumberland, Md.

17. Burial

Date thereof Nov. 28, 1946

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Hafer

Address

Cumberland, Md.

19. Date rec'd by registrar

Nov. 27, 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 804 Columbia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 26, 1946, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 22, 1946, to Nov. 26, 1946,

and that I last saw her alive on Nov. 26, 1946.

Immediate cause of death.

Chronic rheumatic pleuritis
affecting skin & lymph glands

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. V. Dering, M.D.

M. D. or other

Address Cumberland, Md. Date signed Nov. 27, 1946

RECEIVED

DEC 3 1946

BUREAU 8

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

10648

Dr Reeves
Reg. Dist. No. 6

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Years

Hospital, Institution, or street address where death occurred:

48 Main street

How long in hospital or institution?

3. (a) FULL NAME

Eva Myrtle Morrison

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife William Morrison

7. Birth date of deceased (mo., day, yr.) March 18, 1885

8. AGE: Years Months Days If less than one day
61 8 6 hrs. min.9. Birthplace Elk Garden, Mineral, W. Va.
(Town, county, and state)

10. Usual occupation house work

11. Industry or business own home

12. Name John Ross

13. Birthplace VIRGINIA

14. Maiden name ANNA A. Holiday

15. Birthplace CLARKSBURG, W. Va.

16. Informant Mrs. Joseph Conroy

Address Westernport, Maryland

17. Burial Date thereof Nov. 27, 1946
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Philo Cemetery

Location Westernport, Maryland

18. Funeral director Ellsworth S. Boal

Address 111 Church St., Westernport, Md.

19. Nov. 26 1946 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 48 Main street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1946 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/24/46 1946 to 11/24/46 1946

and that I last saw h alive on 11/24/46 1946

Immediate cause of death

Coronary thrombosis

DURATION

13 hr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Dr Reeves M.D.

M. D. or other

Address

Date signed Nov. 26, 1946



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

1754

2411 N. Charles St., Baltimore

10649

CERTIFICATE OF DEATH

Reg. Distr. No.

40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, institution, or street address where death occurred:

209 South Street

How long in hospital or institution?

3. (a) FULL NAME

Reuben O. Morton

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Olive (Bradley) Morton

7. Birth date of deceased (mo., day, yr.) April 16, 1885 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
61 7 3 hrs. min.9. Birthplace Lonaconing, Allegany, Maryland
(Town, county, and state)

10. Usual occupation Retired Foreman

11. Industry or business Celanese Corp. of America

12. Name John Morton

13. Birthplace Scotland

14. Maiden name Elizabeth Crosser

15. Birthplace Scotland

16. Informant Mrs. Olive Bradley Morton

Address 209 South St, Cumberland, Md.

17. Burial Date thereof Nov. 22, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Nov. 22 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 209 Potomac Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-07-5898

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1946, 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7.13.46 to 11.19.46

and that I last saw him alive on 11.19.46

Immediate cause of death

Coronary Thrombosis

or Generalized

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

None

Date of op. None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

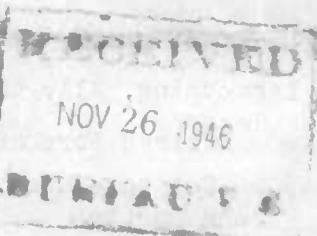
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Joseph Franklin M.D. signed 11-22-46



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

10650

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

3. (a) FULL NAME

MRS. MARGERITE NICHOLS

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED

6.(b) Name of husband or wife JOSEPH NICHOLS

7. Birth date of deceased (mo., day, yr.) APRIL 14, 1902

8. AGE: Years Months Days If less than one day
44 7 1 hrs. min.9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

MOTHER FATHER OWEN WILSON

13. Birthplace WEST VIRGINIA

14. Maiden name OLIVIA HINKIN

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof Nov. 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Nov. 18 1946 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 COLUMBIA ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 15, 1946, at 1:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

NOV. 13, 1946, to NOV. 15, 1946,

and that I last saw her alive on NOV. 15, 1946.

Immediate cause of death

Carcinoma / Breast

DURATION

19 mos

Due to

Due to

Cerebral hemorrhage

10 days

Other conditions

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

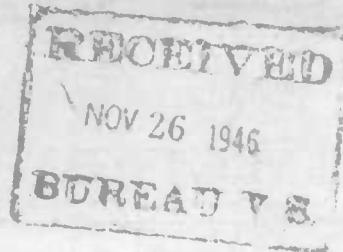
Injured at work?

23. SIGNATURE

J.C. Brummitt, M.D.

M. D. or other

Date signed 10-16-46



2-35

Within corporate limits
DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

10651

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

3. (a) FULL NAME

BABY BOY PARK (PREMATURE)

Charles Lawrence

4. Sex

MALE

S. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) NOVEMBER 18, 1946

8.(c) If alive, give age

years

1946 7:30 P.M.

8. AGE: Years Months Days If less than one day

10 hrs. 16 min.

9. Birthplace MEMORIAL HOSPITAL (Town, county, and state)

10. Usual occupation

11. Industry or business

CHARLES PARK

MOTHER FATHER

12. Name

13. Birthplace

WEST VIRGINIA

14. Maiden name

MARTHA ROWAN

15. Birthplace

MARYLAND

16. Informant

Address

17. Cremation

Burial, cremation, or removal

Date thereof Nov. 19 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Nov. 19 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

MARYLAND

State

CUMBERLAND

County

City or town

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No.

115 1/2 ARCH STREET

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

NOVEMBER 19, 1946

5:40 A.M.

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 18 1946 to Nov. 19 1946
and that I last saw him alive on Nov. 18 1946

Immediate cause of death

Prematurity.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Mseas of Injury

Injured at work?

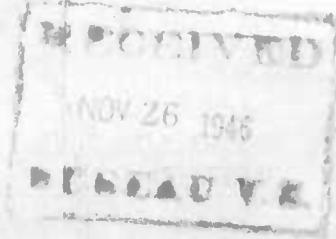
23. SIGNATURE

W.H. Hodges, M.D.

M. D. or other

Address

Cumberland, Md. Date signed 11/19/46



2-35

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age and sex especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9-45-1

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

10652
Reg. Dist. No. 40

1. PLACE OF DEATH:

County..... Allegany
City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? Four months

3. (a) FULL NAME

Shirley Rae Pryor

660
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

April 19, 1946

8. AGE: Years Months Days If less than one day

6 20 .hrs. .min.

9. Birthplace... Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation.....

Infant

11. Industry or business

MOTHER FATHER 12. Name..... Jacob Pryor

13. Birthplace..... Maryland

14. Maiden name..... Shirley Wagus

15. Birthplace..... Maryland

16. Informant..... Jacob Pryor

Address..... Cumberland, Md

17. Burial..... Date thereof..... Nov. 12, 1946
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Cumberland, Md

18. Funeral director..... John J. Hoffer

Address..... Cumberland, Md

19. Nov. 12, 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 520 Virginia Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 11-9-1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-3-1946 to 11-9-1946

and that I last saw her alive on 11-8-1946

Immediate cause of death.....

congestive heart failure

DURATION

6 weeks

Due to..... congenital malformation

of heart

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

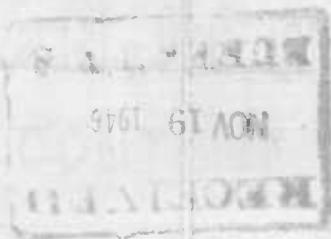
Means of injury

Injured at work?

23. SIGNATURE..... L. R. King M.D.

M. D. or other

Address..... 59 Greene St. Date signed..... 11-9-46



Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

10653

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

154 N. Centre St.

How long in hospital or institution?.....

3. (a) FULL NAME

Bertha E. (Brant) Randall

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife..... David Randall

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)..... Apr. 22, 1877

8. AGE: Years Months Days If less than one day
69 6 18 hrs. min.

Allegany County, Polish Mt., Maryland

9. Birthplace..... (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... Edward Barnes

13. Birthplace..... Maryland

14. Maiden name..... Mary Slider

15. Birthplace..... Maryland

16. Informant..... Mrs. Alice Welsh

Address 154 N. Centre St. Cumberland, Md.
Date thereof Nov. 14, 1946
(Burial, cremation, or removal. Which?)17. Burial..... Hyndman Cem.
Cemetery or crematory.....

Location..... Hyndman, Penna.

18. Funeral director..... Charles L. George

Address..... Cumberland, Md.

19. Date rec'd by registrar..... Nov. 14, 1946
Registrar..... J.P. Franklin, M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 154 N. Centre St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

214-056-7183

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 10, 1946, at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-19-46 to 11-10-46

and that I last saw her alive on 10-8-46

Immediate cause of death.....

Carcinoma Vulva DURATION 2 yrs

Due to..... Carcinomatosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

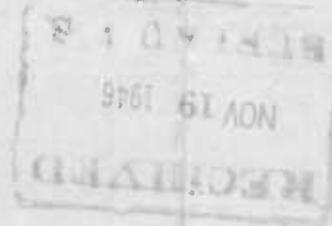
Means of injury.....

Injured at work?

23. SIGNATURE..... C.C. Summerson, M.D.

M. D. or other.....

Address..... Cumberland, Md. Date signed..... Nov. 14, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 96

10654

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH: Allegany
 County: Potowmack
 City or town: 2 weeks
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Maryland Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Maryland County: Allegany
 City or town: Lake Lure (If outside city or town limits, write RURAL and give nearest town)
 Street No.: Park Place (If rural, give LOCATION)

2.(a) If veteran, name war: ✓3. (b) Social Security Number: ✓3. (a) FULL NAME: Dennie Young Ravencroft

4. Sex:	5. Color or race:	6. (a) Single, married, widowed, or divorced:
---------	-------------------	---

Female White Married

6. (b) Name of husband or wife: Ferdinand Ravencroft

7. Birth date of deceased (mo., day, yr.): Sept. 13 1890

6. (c) If alive, give age: 56 years

8. AGE: Years: 56 Months: 2 Days: 14 If less than one day: hrs. min.

9. Birthplace: Gorham, Allegany Co., Md.
 (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

12. Name: Dannie Young

13. Birthplace: Scotland

14. Maiden name: Agnes McMillan

15. Birthplace: Vale Summit

16. Informant: Mrs. Ferdinand Ravencroft

Address: Concord, Md.

17. Burial: Burial Date thereof: June 30 1946
 (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Concord, Md.

18. Funeral director: M. Eichhorn

Address: Concord, Md.

19. 11-22 1946 Mrs. Dailey V. Roe
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 27 1946 at 2:00 A.M.I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 23 1946 to Nov 27 1946 and that I last saw her alive on Nov 26 1946.

Immediate cause of death: ruptured blood vessel of neck, eroding into aneurism of large artery
 Due to: constriction of
 Due to: large artery

DURATION: 3 Day

Other conditions: _____
 (Include pregnancy within 8 months of death)

Major findings of operations: _____ Date of op.: _____

Autopsy results: _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: Wm. Gage Jr. M.D. M. D. or other: _____Address: Port Huron, Md. Date signed: Nov 27 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9th

CERTIFICATE OF DEATH

Reg. Dist. No. 10655

1. PLACE OF DEATH:

County Allegany
City or town Rural Old Town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R.D. #1

How long in hospital or institution?

3. (a) FULL NAME

Robert Wilson Rawlings

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife Lillie Whitmire Rawlings

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1865

8. AGE:	Years	Months	Days	If less than one day
	81	1	18	hrs. min.

6. Birthplace Near Burlington W. Va.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Farmer

12. Name Elijah Rawlings

13. Birthplace W. Va.

14. Maiden name Hester Ann Welsh

15. Birthplace W. Va.

16. Informant Mr. Herman Rawlings

Address Old Town, Md.

17. Burial Date thereof Nov. 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Porter Cemetery

Location Near Eckhard, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Nov 26, 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural Old Town
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that the deceased from

11-25-46 to 11-23-46 and that I last saw him alive on 11-11-46

Immediate cause of death

Antherosclerosis myocardial degeneration

Due to

Due to

Other conditions Fibrosis prostate with contracture vesical orifice

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard Wilson

M. D. or other

Address Cumberland, Md. Date signed 11-25-46

RECEIVED

DEC 4 1946

BUREAU V 6

2-35

Within corporate limits
DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 40

10656

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Memorial Hospital

How long in hospital or institution? 1 DAY

3. (a) FULL NAME

FRANK RAY

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6.(b) Name of husband or wife

None

7. Birth date of deceased (mo., day, yr.)

UNKNOWN

6.(c) If alive, give age

1886

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

PA. Bucks Valley, Penna,

(Town, county, and state)

10. Usual occupation

Plasterer

11. Industry or business

MOTHER FATHER

FRANK RAY

13. Birthplace

Penna.

14. Maiden name

AMANDA BEATTY

15. Birthplace

Penna.

16. Informant

James Ray

Address

Artemas, Penna.

Burial

17. Date thereof Nov. 21, 1946

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Christian Church Cem.

Cemetery or crematory

Bucks Valley, Penna.

18. Funeral director

H. Wayne George

Address

Cumberland, Md.

19. Nov. 20

1946

(Date rec'd by registrar)

J. P. Franklin, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ALLEGANY

City or town FLINTSTONE, MD.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Flintstone Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 18

1946, at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-17-1946 to 11-18-1946

and that I last saw him alive on 11-18-1946

Immediate cause of death

Myocardial degeneration?
+ arteriosclerosis

DURATION

Due to

Due to

Other condition Chronic cellulitis?

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Howard Tolson, M.D.
Cumberland, Md.

M.D. or other

Signature

11-18-46

RECORDED

NOV 26 1946

80-355

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

★ 10657

CERTIFICATE OF DEATH

Reg. Dist. No. 80

2
1. PLACE OF DEATH:
County..... Allegany
City or town..... Midland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 yrs
Hospital, institution, or street address where death occurred: home

How long in hospital or institution?

3. (a) FULL NAME

Miss Annie A. Reilly

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 11, 1888

8. (c) If alive, give age 78 years

8. AGE: Years 58 Months 7 Days 22 If less than one day hrs. min.

9. Birthplace Ocean City, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation School Teacher

11. Industry or business Allegany Co. Public School

12. Name MacPhail Reilly

13. Birthplace Wales

14. Maiden name Mary Kerssey

15. Birthplace Ireland

16. Informant Miss B. Reilly

Address Midland, Md.

17. Burial Date thereof Nov. 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michaels Cemetery

Location Frostburg, Md.

18. Funeral director M. C. Dickhour

Address Lonaconing, Md.

19. Nov. 5 1946 Janette M. Boal
(Date rec'd by registrar)2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1946 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her Dead Nov. 3 1946 to 1946

Immediate cause of death

Chronic Myocarditis

DURATION several years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. or other

Address Cumberland, Md. Date signed 11-4-1946
Deputy Medical Examiner - Allegany Co.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

10658

Reg. Dist. No. 40

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? a few minutes

Hospital, Institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? a few minutes

3. (a) FULL NAME

Le Roy Riggelman4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Aug. 31 1946 6.(c) If alive, give age..... years8. AGE: Years 2 Months 28 Days If less than one day hrs. min.9. Birthplace Moorefield, Hardy County, W. Va. (Town, county, and state)

10. Usual occupation.....

None

11. Industry or business

FATHER Unknown MOTHER Unknown12. Name " 13. Birthplace "MOTHER Fleta Riggelman FATHER Fleta Riggelman14. Maiden name Fleta Riggelman 15. Birthplace Moorefield, W. Va.16. Informant Fleta Riggelman Address Moorefield, W. Va.17. Burial Newhouse Cemetery Date thereof Dec. 2, 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Newhouse Cemetery Location Moorefield, W. Va.18. Funeral director William H. Kight Address Cumberland, Md.19. Nov. 30, 1946 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W.Va. County Hardy CountyCity or town Moorefield, W. Va. (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1946 at 4.20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. im alive Dead Nov. 29 1946

Immediate cause of death.....

Pulmonary oedemaDue to malnutrition and premature when born months

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

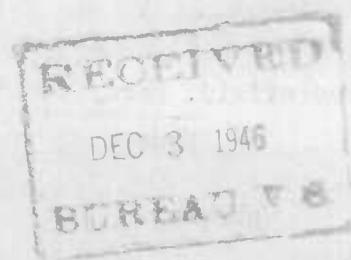
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Medical Examiner Injured at work?23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M.D. DoctorAddress Cumberland Md. Date signed 11/29/46



1-35

Dr. Bennett
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

10659

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

80 Years

How long in above place of death?

Hospital, institution, or street address where death occurred:

307 Baltimore Ave

How long in hospital or institution?

3. (a) FULL NAME

Hannah Belle Ring

4. Sex 5. Color or race 8. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife..... C. S. Ring

7. Birth date of deceased (mo., day, yr.)..... June 14 1866

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
80 5 14 hrs. min.9. Birthplace..... Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation..... House Wife

11. Industry or business..... Own House

FATHER
12. Name..... Jacob Rice

13. Birthplace..... Cumberland, Md.

MOTHER
14. Maiden name..... Rebecca Thorp

15. Birthplace..... Cumberland, Md.

16. Informant..... Mrs. D. L. Taylor

Address 307 Balto Ave, Cumberland, Md.

17. Burial..... Date thereof 12/1/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Cumberland, Md.

18. Funeral director..... William H. Kight

Address Cumberland, Md.

19. Nov. 29 1946 J. P. Franklin, M.D.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 307 Baltimore Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 28 1946 at 1-25 A.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from
Nov. 28 1946 at 1-25 A.M. to Nov. 28 1946
and that I last saw her alive on Nov. 28 1946.

Immediate cause of death.....

Coronary Thrombosis - Myocarditis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... cleagh · farrar

M. D. or other

Address..... Cumberland Date signed..... 11/29/46.

RECEIVED

DEC 3 1946

BUREAU OF

1-35

Within corporate limits
1700 ft

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incise text age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25th)

CERTIFICATE OF DEATH

10660 40

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6.8 years

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 12 days

3. (a) FULL NAME

George H. Schultz

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Rachel E. Humberson

7. Birth date of deceased (mo., day, yr.)

March 23, 1878

6. (c) If alive, give age 65 years

8. AGE: Years

Months

Days

If less than one day

68 7 12 hrs. min.

9. Birthplace Cumberland, Allegany Co., Md.

(Town, county, and state)

10. Usual occupation Transfer

11. Industry or business Own Business

12. Name George Schultz

13. Birthplace Germany

14. Maiden name Christina Schade

15. Birthplace Germany

16. Informant Mrs. Rachel E. Schultz

Address 455 Walnut St.

17. Burial Date thereof Nov. 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Luke's Lutheran Cem.

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Nov. 8, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 455 Walnut St.

(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1946, at 11:52 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 25 1946, to Nov 5, 1946,

and that I last saw him alive on Oct 6, 1946.

Immediate cause of death.

Acute nephritis
with albumin 3 days

Due to Acute nephritis
with albumin

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John S. Keenan, M.D.
Cumberland, Md. Date signed Nov. 7/46



1-35

Within corporate limits

DR. ELIASON
DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

★ 10661

Reg. Dist. No. 4

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

9-45-154

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 8 DAYS

3. (a) FULL NAME

Joseph Wm. Schupfer Jr.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

OCT. 29, 1946

8. AGE:

Years

Months

Days

If less than one day

0 28

hrs.

min.

9. Birthplace

MARYLAND, Cumberland, Allegany Co.

(Town, county, and state)

10. Usual occupation

INFANT

11. Industry or business

MOTHER FATHER

12. Name JOS.EPH WM. SCHUPEER

13. Birthplace MARYLAND, Cumberland

14. Maiden name MARIE [REDACTED] Davis

15. Birthplace WEST VIRGINIA, Morgantown

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 27, 1946

(month) (day) (year)

Cemetery or crematory

Sts. Peter & Paul

Location CUMBERLAND, MD.

18. Funeral director

John J. Hader

Address

CUMBERLAND, MD.

19. Rec'd by registrar

Nov. 27, 1946

(Date rec'd by registrar)

J. P. Franklin, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 708 COLUMBIA AVE.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 26, 1946, 1:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOV. 18, 1946, to NOV. 26, 1946,

and that I last saw him alive on NOV. 26, 1946.

Immediate cause of death Pyloric stenosis

Prematurity

DURATION 2 days

Due to

Due to

Other conditions Abdominal hemorrhage 3 days

(Include pregnancy within 8 months of death)

Major findings of operations Pyloric stenosis

Date of op. 11/22/46

Autopsy results Hemorrhage from incision

PHYSICIAN: Please underline the cause to which death should be charged medically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

Dr. H. Hodges, M.D.

M. D. or other

Address CUMBERLAND, MD. Date signed 11/27/46

RECEIVED

DEC 3 1946

BUREAU OF INVESTIGATION

I-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-2

CERTIFICATE OF DEATH

10662 90
Reg. Dist. No.

1. PLACE OF DEATH:

County HanoverCity or town Frostburg MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Oct 26, 1946Hospital, institution, or street address where death occurred: Maryland HospitalHow long in hospital or institution? one week

3. (a) FULL NAME

Herman Shockley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleWhiteMarried

6. (b) Name of husband or wife

Susan Werner Shockley6. (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.)

Sept. 22, 1865

8. AGE:

Years 81Months 1Days 10If less than one day
hrs. min.

9. Birthplace

Somerset Co.

(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

12. Name

Eli Shockley

13. Birthplace

Somerset Co., Pa.

14. Maiden name

Margaret Mazer

15. Birthplace

Somerset Co., Pa.

16. Informant

Mrs. F. J. Glass

Address

Boswell, Pa.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 5, 1946

(month) (day) (year)

Cemetery or crematory

White Oak Cemetery - Meyersdale Rd.

Location

Meyersdale, Pa. R.D. 3

18. Funeral director

Hillman Funeral Service

Address

Meyersdale, Pa.19. 11-2

(Date rec'd by registrar)

19. 1946 Mrs. Harvey A. Ross

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa.County SomersetCity or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. 3

(If rural, give LOCATION)

2.(a) If veteran, name war W.W.II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1946 st. 7:40 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-26 1946, to 11-2 1946and that I last saw him alive on November 2 1946

Immediate cause of death

Carcinoma right cheek
metastasis to lung

DURATION

2 yrs.
3 weeks

Due to

Senile

Due to

Atherosclerosis

(Include pregnancy within 8 months of death)

Major findings at operations

X Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H.C. Diehl, M.D.

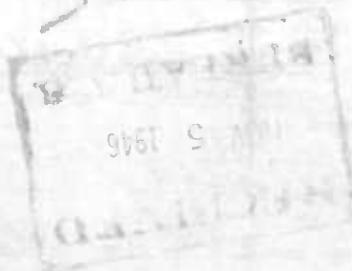
M. D. or other

Address Frostburg, Md. Date signed 11/2/46

1946-1947 STATE PROGRAM

1946-1947 STATE PROGRAM

58-1



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

10663

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH:		<i>Allegany Lonaconing</i>		
County				
City or town		(If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death?		175 yrs		
Hospital, institution, or street address where death occurred:		<i>Jackson</i>		
How long in hospital or institution?				
3. (a) FULL NAME		<i>Ella Lora Frederick Sloan</i>		
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
Female	White	Widowed		
8. (b) Name of husband or wife		<i>James Mair Sloan</i>		
7. Birth date of deceased (mo., day, yr.)		6. (c) If alive, give age _____ years		
July 6, 1857				
8. AGE:		Years	Months	Days
95		4	13	If less than one day
hrs.		min.		
9. Birthplace		<i>Berlin, Pennsylvania</i>		
(Town, county, and state)				
10. Usual occupation		<i>Housework</i>		
11. Industry or business		<i>Own home</i>		
FATHER	12. Name			<i>Johnn Frederick</i>
MOTHER	13. Birthplace			<i>Germany</i>
	14. Maiden name			<i>Anna Eckhardt</i>
	15. Birthplace			<i>Germany</i>
16. Informant		<i>Miss Florence Sloan</i>		
Address		<i>Lonaconing, Md</i>		
17. Burial		Date thereof	Nob. 21, 1946	
(Burial, cremation, or removal, Which?)		(month)	(day)	(year)
Cemetery or crematory		<i>Allegany Cemetery</i>		
Location		<i>Hrostburg, Md.</i>		
18. Funeral director		<i>In. E. Pickhorn</i>		
Address		<i>Lonaconing, Md</i>		
19. Date rec'd by registrar		<i>Nov. 20 1946 Janette M. Boal</i>		

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Allegany*
 City or town *Lonaconing* (If outside city or town limits, write RURAL and give nearest town)
 Street No. *Jackson Street* (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 19 1946* at *12:45 P.M.*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov. 7 1946 to *Nov. 12 1946* and that I last saw her alive on *Nov. 15 1946*

Immediate cause of death

arterio sclerosis

DURATION

Due to *old age*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *Henry Dr. Hodges* M. D. or otherAddress *Lonaconing, Md.* Date signed *Nov. 20 1946*

JUN 23 1945

BUREAU OF INVESTIGATION

1-35

Within corporate limits

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10-10

CERTIFICATE OF DEATH

10664

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

ALLEGANY

County

CUMBERLAND, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 16 DAYS

3. (a) FULL NAME

MR. D. GRANT SMITH

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

WIDOWED

6.(b) Name of husband or wife

VIRGINIA PORTER

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

80

:

>

hre.

min.

9. Birthplace.....

WEST VIRGINIA

(Town, county, and state)

10. Usual occupation.....

PRINTER

11. Industry or business

>

12. Name.....

WILLIAM SMITH

13. Birthplace.....

MARYLAND

14. Maiden name.....

Makarov

15. Birthplace.....

16. Informant.....

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Grafton W Va

Location.....

41

18. Funeral director.....

Bartlett General Home

Address

Grafton W Va

19. Nov. 13 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... WEST VIRGINIA County..... TAYLOR

City or town..... GRAFTON (If outside city or town limits, write RURAL and give nearest town)

Street No..... ETHEL ST.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... NOVEMBER 13 1946 at 3:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-28-1946 to 11-13-1946

and that I last saw him alive on 11-12-1946

Immediate cause of death.....

Carcinoma Prostate

DURATION

Duo to.....

Duo to.....

Other conditions.....

arteriosclerotic

(Include pregnancy within 3 months of death)

Major findings and operations.....

perarectal prostate resection Date of op. 11-11-46

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

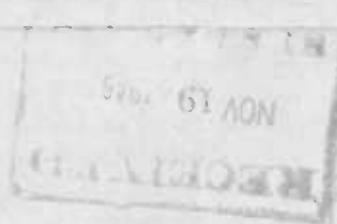
Injured at work?

23. SIGNATURE.....

M. D. Father

Address..... Cumberland, Md Date signed 11-13-46

2-31-



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 402

CERTIFICATE OF DEATH

10665

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

235 Cumberland St.

How long in hospital or institution?

3. (a) FULL NAME

Rose Smith

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

white

married

6.(b) Name of husband or wife

Joseph Smith

7. Birth date of deceased (mo., day, yr.)

Dec 3, 1873

6.(c) If alive, give age 94 years

8. AGE:

Years

Months

Days

It less than one day

72 " 12 hrs. min.

9. Birthplace

Carnegie, Allegheny Co., Pa.

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

At Home

12. Name

Gottlieb Hall

13. Birthplace

Carnegie, Pa.

Unknown

14. Maiden name

15. Birthplace

16. Informant

Mrs. Hattie Kirk

Address 800 Columbia Ave - Cumb Md.

17. Burial

Date thereof Nov 18 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St Peter & Paul Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Haffey

Address

Cumberland, Md.

19. Nov 17, 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 527 Rose Hill Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 15

1946, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

and that I last saw h. ~~her~~ Dead Nov 15

1946

Immediate cause of death

Cessation of the decaying
process

DURATION

several
years.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

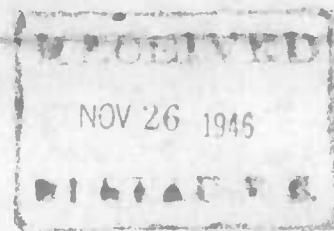
Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland, Md.

Date signed Nov 16, 1946



2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 41



10666

CERTIFICATE OF DEATH

Reg. Dist. No. 40

M
Live correct age
I have carefully
written this certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 yrs

Hospital, institution, or street address where death occurred:

437 Walnut St.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex Female 5. Color or race White Married

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Charles Smith

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1884

8. AGE: Years Months Days If less than one day

67 6 21 hrs. min.

9. Birthplace Cumberland Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

12. Father George Windermuth

13. Birthplace Md.

14. Mother Wilhelmina Borcherk

15. Birthplace Md.

16. Informant Chas. Smith

Address Cumberland

17. Burial Date thereof 11-9-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland

18. Funeral director Sonenstein Joe

Address Cumberland

19. Nov. 9 1946 J. P. Franklin, M.D.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 437 Walnut St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 6 1946 to — 1946 —

and that I last saw her alive on November 6 1946 —

Immediate cause of death cerebral hemorrhage

DURATION 30 minutes

Due to arteriosclerosis

2

Due to

Other conditions Diabetes, moderate senes

with acidosis & ketosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

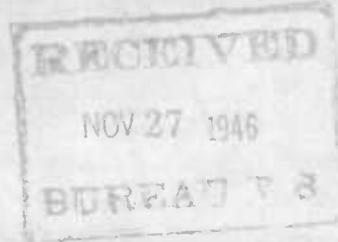
23. SIGNATURE Seville & Weissman M.D.

M. D. or other

Address Presabotower, Md. Date signed Nov 1946



1-35



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. Physicians: please write the causes of death clearly and legibly.

Louis Brings

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10668

50

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany

City or town Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, institution, or street address where death occurred:

45 So. Winchester Road

How long in hospital or institution?

3. (a) FULL NAME

Henry Snyder

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Maria Benvenutti Benn

7. Birth date of deceased (mo., day, yr.)

February 5, 1860

6.(c) If alive, give age years

8. AGE:

Years 86

Months 9

Days 25

If less than one day

hrs. min.

9. Birthplace Cumberland

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name

?

13. Birthplace

Germany

?

14. Maiden name

Germany

?

16. Informant Mrs. Pearl Sindy

Address Cresaptown, Md.

17. Burial

Date thereof December 2, 1946

(month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hobbs

Address Cappaghland, Cumberland

19. (Date reg'd by registrar) 19..... 19.....

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 45 So. Winchester Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1946 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him alive on 11-3-1946

Immediate cause of death

Congestive heart failure

DURATION

2 months

Due to chronic myocarditis

2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE Louis Brings M.D.

M. D. or other

Address 59 Green St.

Date signed 12-1-46

RECEIVED

DEC 13 1946

B READING

2-35

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

10669

40

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.

Allegany.

City or town.

Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

80 yrs.

Hospital, institution, or street address where death occurred:

520 Bedford St.

How long in hospital or institution?

3. (a) FULL NAME

John Peter Sporel

4. Sex

Male

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Catherine Roeder

7. Birth date of deceased (mo., day, yr.)

July 4 1866

6. (c) If alive, give age years

8. AGE:

Year

Months

Days

If less than one day

80

4

15

hrs.

min.

9. Birthplace

Cumberland Ind.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Garage Owner

FATHER

12. Name

Geo. M. Sporel

13. Birthplace

Germany

14. Maiden name

Elizabeth Herpich

15. Birthplace

Germany

16. Informant

J. P. Sporel

Address

Cumberland

17. Burial

Date thereof Nov 21 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Baptist Cem.

Location

Cumberland

18. Funeral director

H. H. Stein Inc

Address

Cumberland

19. Nov. 20 1946

J. P. Franklin, M.D.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 520 Bedford St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 10 1946 to Nov 19 1946

and that I last saw him alive on Nov 19 1946

Immediate cause of death

Myocardial Failure

DURATION

Due to Chronic Myocarditis

Due to deformities of old age

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland Md Date signed 11/19/46

RECEIVED

NOV 26 1946

BUREAU V.C.

2-35

Within Corporate Limits MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

10670

Reg. Dist. No. 40

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

Allegany Hospital, Cumberland, Maryland

How long in hospital or institution? 22 days

3. (a) FULL NAME

George Steen Steen

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Married
-------------	------------------------	---

6.(b) Name of husband or wife Mrs. Elizabeth Steen Steen

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) 1/26/1868

8. AGE: Years	Months	Days	It less than one day
78	5 10	3	hrs. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name James Steen

13. Birthplace Scotland

14. Maiden name Catherine Mathias

15. Birthplace Scotland

16. Informant Theodore Stegmaier

Address 7th & Cumberland, Md.

17. Burial Date thereof December 21 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hedges

Address Cumberland, Md.

19. Name Joseph D. Johnson
(Date rec'd by registrar) 1946
Signature Joseph D. Johnson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Christie Road 141 Reynolds St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

220-10-0122

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1946 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 46 to November 29 1946, to November 29 1946, and that I last saw him alive on November 29 1946.

Immediate cause of death Pulmonary Tuberculosis of lung 2 months DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. J. Johnson

M. D. or other

Address Cumberland, Md. Date signed 11-29-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore, 1600

CERTIFICATE OF DEATH

Reg. Dist. No. 40

10671

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

3. (a) FULL NAME

Roger Lee Stottlemyer

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1946

6. (c) If alive, give age years

8. AGE: Years Months Days It less than one day
2 hrs. 40 min.

9. Birthplace Cumberland, Allegany, Md.

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

12. Name Michael O. Stottlemyer

13. Birthplace Cresaptown, Md.

14. Maiden name Delores Morris

15. Birthplace Corriganville, Md.

16. Informant Edna Morris

Address Etch, Cumberland, Md.

17. Burial Date thereof Nov. 27, 1946
(Burial, cremation, or removal. Which?) month (day) (year)

Cemetery or crematory Porters Cemetery

Location Hyndman, Penna.

18. Funeral director John J. P. Franklin

Address Cumberland, Md.

19. Nov. 27, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Allegany

City or town Etch, Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Tt. b Location (Locality)

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1946 at 1P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 25 1946 to Nov. 25 1946

and that I last saw him alive on Nov. 25 1946

Immediate cause of death Asphyxia

DURATION

Due to Breach delivery

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Name of injury

Injured at work?

23. SIGNATURE

Mrs. Alice H. We

M. D. or other

Address 1335 Avenue Date signed 11/26

RECEIVED

DEC 3 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 114

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Eastland mines

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Clarence Rudolf Swain

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Mildred Steele

7. Birth date of deceased (mo., day, yr.)

July 4th, 1921

6. (c) If alive, give age 21 years

8. AGE:

Years 25

Months 4

Days 9

If less than one day

hrs.

min.

9. Birthplace Morgantown, Allegany, Md.

(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal Mine

MOTHER FATHER 12. Name George Wm. Swain

13. Birthplace Morgantown, Md.

14. Maiden name Clara Thompson

15. Birthplace Tazette County

16. Informant Mr. George Wm. Swain

Address Morgantown, Md.

17. Burial Date thereof 11-15-1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Jacob Blaper

Address Frostburg, Md.

19. 11-13 1946 (Date rec'd by registrar)

20. Mrs. Harvey A. Roe

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Eastland mines

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

315-18-8074

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 ..., to

19 ...
18 46

and that I last saw him Dead

Immediate cause of death A mine accident

Intraosseous hemorrhage bone

Due to a crushed skull

Due to A fall of roof coal, in Mine No. 4.

Was killed instantly.

cause of

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

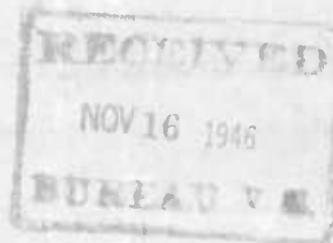
Injured at work? Yes

23. SIGNATURE J. V. Denning M.D.

M. D. or other

Address Cumberland, Md. Date signed 11-22-46

Deputy Medical Examiner - Allegany Co.



1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14a

10673

Reg. Dist. No. 40

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

533 Necessity St.

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Mary E. Uhl

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced

Female white Widowed

8.(b) Name of husband or wife John H Uhl

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22 1877

8. AGE: Years 69 Months 5 Days 11 If less than one day hrs. mln.

9. Birthplace Mt. Savage Md.

(Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business

at Home

12. Name John Waltons

13. Birthplace Md.

14. Maiden name Anna M. Folk

15. Birthplace Md.

16. Informant Mrs. Rae Anna Markwood

Address

Cumberland

17. Burial Date thereof 11-6-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory St George Cem.

Location St George Md

18. Funeral director Louis Stein Inc

Address Cumberland

19. Nov. 6 46 Jos. Franklin M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

H. V. Deming

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1946 12.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 10. 18.

and that I last saw her Dead Nov. 3

1946

Immediate cause of death

Coronary occlusion

DURATION

at once

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE H.V. Deming M.D. *H.V. Deming* M.D. or other

Address Cumberland, Md. Date signed Nov. 4, 1946

Deputy Medical Examiner - Allegany Co.

NOV 13 1946

DO NOT READ V 6

2-35

Within corporate limits

M
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

Date rec'd by registrar

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore No. 100

CERTIFICATE OF DEATH

Reg. Dist. No.

10674 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 Years

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

1 day

3. (a) FULL NAME

Edward W. Valentine

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

7. Birth date of

deceased (mo., day, yr.)

November 10, 1886

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

59

11

23

hrs.

min.

9. Birthplace

Pattersons Creek, W. Va.

(Town, county, and state)

10. Usual occupation

11. Industry or business

B&O RR

MOTHER FATHER

12. Name

Theodore Valentine

13. Birthplace

Allegany Co., Md.

14. Maiden name

Mary Elizabeth Long

15. Birthplace

Kentucky

16. Informant

Gilbert Garlitz

Address

20 So. Mechanic St.

17. Burial

Data thereof Nov. 6, 1946
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Hoban

Address

Cumberland, Md.

19. Date rec'd by registrar

Nov. 6, 1946.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 68 Cresap St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

220-10-2442

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 3

1946 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that last saw him Dead Nov. 3

Immediate cause of death

Cerebral hemorrhage

DURATION

about 20 hrs.

Due to Fracture of the skull

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, asphyxia, or homicide accident Date of 11.3.46

Where did injury occur? Cumberland Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, place of work B&ORRY Crossing

Means of injury Auto hit him his injured at work

head hit drive wheel of B&ORRY engine

23. SIGNATURE H.V. Deming M.D.

Signature

M. D. or other

Address

Date signed 11-4-46

NOV 13 1946

FBI - BUREAU OF INVESTIGATION

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-8

10675

40

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

68 yrs

Hospital, Institution, or street address where death occurred:

142 Polk St.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Bertha Matthews

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day
68 3 23 hrs. min.

9. Birthplace

(Town, county, and state)
Cumberland Md.

10. Usual occupation

Machinist

11. Industry or business

Belmore Corp of C.

12. Name

Frederick Jacob Neisenmiller

13. Birthplace

Cumberland Md.

14. Maiden name

Mary Marty

15. Birthplace

Cumberland Md.

16. Informant

Mrs Bertha Neisenmiller

Address

Cumberland Md.

17. Burial

Date thereof Nov 5 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

St Peter & Pauls Cem.

Location

Cumberland Md.

18. Funeral director

Tomis Stein Fox

Address

Cumberland

19. Nov 4

(Date rec'd by registrar)

19 46

J. P. Franklin, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

220-10-9157

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 5

1946 NOV 1

1946

to

1946

dead that I last saw h.m. alive on Nov 1

1946

Immediate cause of death

Lympho-sarcoma of esophagus & fundus of stomach

Due to

DURATION

(3)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

H. V. Denning M.D.

M. D. or other

Address

Cumberland Md.

Date signed

RECD

SOW 13 1946

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10676

Reg. Dist. No. 40

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Allegany

City or town.....

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

8 days

Hospital, Institution, or street address where death occurred.....

allegany hospital

How long in hospital or institution?.....

8 days

3. (a) FULL NAME

Carrie Kaufman White

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

widowed

6. (b) Name of husband or wife.....

Edward H. White

7. Birth date of deceased (mo., day, yr.)

6st 31 1869

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

It less than one day

hrs. min.

9. Birthplace.....

Philadelphia Pa

(Town, County, and state)

10. Usual occupation.....

House keeper

11. Industry or business

Elias Kaufman

MOTHER FATHER

Germany

13. Birthplace

Germany

14. Maiden name.....

Babette Heish

15. Birthplace

Germany

16. Informant.....

Mrs. Frank Tasker

Address

Washington D. C.

17. Burial.....

Burial

Date thereof..... Nov 11 1946

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Baltimore Hebrew

Cemetery or crematory

Blair Rd Baltimore Md

Location

Lanis Shin Tse

18. Funeral director

Cumberland Md

Address

J. P. Franklin, M.D.

19. Nov. 10 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

Maryland County Allegany

City or town..... Cumbeland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 514 Washington Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Nov. 9

1946 at 4³⁰ am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1 1946 to Nov. 9 1946

and that I last saw h. s. alive on Nov. 9 1946

Immediate cause of death..... Renal failure

- arteriosclerosis

DURATION

9 days

Due to..... Post-op. pneumonia

3 days

Due to..... Intestinal Obstr.
(peritoneal band)

12 days

Other conditions.....

Hypertension

several yrs

(Include pregnancy within 8 months of death)

Major findings of operations..... Narrow band from
gastro-colic lig to mesentery & complete
obstruction of jejunum Date of op. Nov 1, 1946

Analogous results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

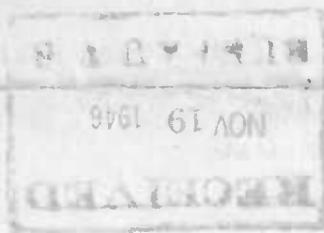
23. SIGNATURE.....

Amelia M.

M. D. or other

Address 115 S. Centre St Date signed 11-9-46

Cumberland Md.



NOV 19 1946

Within corporate limits
M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, name and address of deceased should be given. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-2

CERTIFICATE OF DEATH

10677 40

Reg. Dist. No.

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

86 yrs

Hospital, institution, or street address where death occurred:

57 S. Centre St.

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Ellen Willard

3. (b) Social Security Number

None

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

it less than one day

86 4 23 hrs. min.

9. Birthplace

Cumberland Md.

(Town, county, and state)

10. Usual occupation

House keeper

11. Industry or business

at Home

MOTHER FATHER

John P. Willard

13. Birthplace

Md.

14. Maiden name

Mary Ann Reid

15. Birthplace

Cumberland Md.

16. Informant

Helene Lee

Address

Cumberland Md.

17. Burial

Date thereof Nov 5 46

(Burial, cremation, or removal Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cem.

Location

Cumberland Md.

18. Funeral director

Loris Stein Inc.

Address

Cumberland

19. Date rec'd by registrar

Nov 5 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 57 S. Centre St.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1946 at 4:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mary 1946 to Nov 3 1946

and that I last saw h.s. alive on Nov 1 1946

Immediate cause of death

Infection of the peritoneum
Candida muscular
Wound disease.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

D. B. Forn MD M. D. or other

Address Medical Building Date signed Nov 11 1946

13 1946
U.S.A.F.
2-35

Within corporate limits

DR. R. WMS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

10678

CERTIFICATE OF DEATH

Reg. Dist. No. 40

M
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? TWO DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town near CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. BOWMAN'S ADDITION, Route 3
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

3. (a) FULL NAME

JAMES A. WILSON

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Florence Wilson

7. Birth date of deceased (mo. day, yr.) Apr. 21, 1881
6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
65 6 15 hrs. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER 12. Name Edward Wilson

13. Birthplace So. Carolina

14. Maiden name Emily Dixon

15. Birthplace Va.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. Burial Date thereof Nov. 12, 1946
(Burial, cremation, or removal. Which?)

Cemetery or crematory Allegany County Home Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Nov. 9, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 6, 1946 19 at 10:00 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/6/46 19 to 11/6/46 19

and that I last saw him alive on 11/6/46 19

Immediate cause of death

Cerebral Hemorrhage

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland, Md. Date signed 11/6/46



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 100-ay

CERTIFICATE OF DEATH

Reg. Dist. No. 90

10875

1. PLACE OF DEATH:

County.....

allegany

City or town.....

Frostburg

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

66 N. Wall St.

How long in hospital or institution?.....

3. (a) FULL NAME

Bertha Raphae Winner

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife.....

Harry Winner

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Sept 10 - 1894

8. AGE:

Years 52 Months 2 Days 12 If less than one day

hrs. min.

9. Birthplace.....

Eckhart - alle - md

(Town, county, and state)

10. Usual occupation.....

housewife

11. Industry or business

Frank Raphae

12. Name.....

Eckhart, md.

13. Birthplace.....

Sarah Alice

Eckhart, md.

14. Maiden name.....

Mrs. Robert Sweetser

15. Birthplace.....

Frostburg, md.

16. Informant.....

Address

Frostburg, md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof. Nov 25-1946

(month) (day) (year)

Cemetery or

Location

allegany

Frostburg, md.

18. Funeral director.....

Address

Frostburg, md.

19. (Date rec'd by registrar)

11-25 1946 M. H. Nealey N-A-10

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

md

County.....

allegany

City or town.....

Frostburg

if outside city or town limits, write RURAL and give nearest town)

Street No.....

66

n. Water

(if rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 22 1946 at 3:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 1946 to Nov 22 1946

and that I last saw her alive on Nov 13 1946

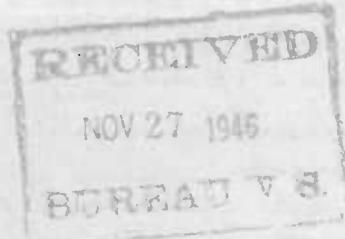
Immediate cause of death

Pulmonary embolism

embolism

contusion

bruise



1-35

Within corporate limits DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10680

40

1. PLACE OF DEATH:

ALLEGANY
County

CUMBERLAND
City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

53 DAYS

3. (a) FULL NAME

MR. GEORGE W. WINTERS

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

GERTRUDE LONG

7. Birth date of deceased (mo., day, yr.)

JULY 18, 1863

6. (c) If alive, give age years

8. AGE:

83

Years

2

Months

21

Days

It less than one day

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

RETIRED

11. Industry or business

U.S. Post Office Dept.

MOTHER FATHER

12. Name

W. A. WINTERS

PENNSYLVANIA

13. Birthplace

ELIZA CECIL

PENNSYLVANIA

14. Maiden name

MEMORIAL HOSPITAL

CUMBERLAND, MD.

15. Birthplace

16. Informant

Address

Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

20. Date thereof

(month)

(day)

(year)

Nov. 11, 1946

HillCrest Burial Park

Cumberland, Md.

Charles L. George

Cumberland, Md.

Nov. 11,

19

46 J. P. Franklin, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND

County

ALLEGANY

City or town

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No.

417 GREENE ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

NOVEMBER 9

19 46, at 1:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 8 1946, to Nov. 9 1946

and that I last saw him alive on Nov. 8

1946

Immediate cause of death

Pulmonary embolism

Due to Amputation right leg above knee

Due to Arterio - venous gangrene
right lower leg.

Other conditions Hemiplegia.

(Include pregnancy within 3 months of death)

Major findings of operations

Gangrene right lower

extremity

Date of op. Nov. 8, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wyle M. Faw, Jr. M.D.

M. D. or other

Address 5 Washington St. Date signed Nov. 10, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age

years

Oct. 17 - 1969

8. AGE:

Years

Months

Days

If less than one day

37 1 4 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal, Which?

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

1946

H. A. Roe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

314

City or town

Frostburg

Street No.

316 Center

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/30 1946 to 11/12 1946

and that I last saw her alive on 11/18 1946

Immediate cause of death

Carcinoma Cervix
with abdominal metastases

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Carcinoma Cervix
(Biopsy) Date of op. July 1974

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

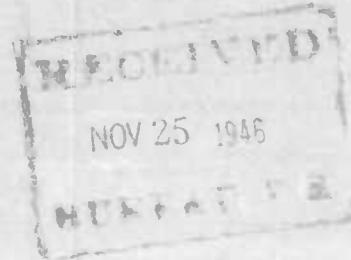
Means of injury

Injured at work?

23. SIGNATURE

Hilda Journeycake, M.D. M. D. or other

Address Frostburg, Md. Date signed 11/22/46



1-35

Within corporate limits

DR BROADRUP

Wafec

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

★ 10681

CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH:

County ALLEGANY CO.

City or town CUMBERLAND, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 25 DAYS

3. (a) FULL NAME

MRS MARGARET WYSNER

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE WHITE

MARRIED

6. (b) Name of husband or wife

JOSEPH WYSNER

7. Birth date of deceased (mo., day, yr.)

JUNE 12, 1860

6. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

86

4

21

hrs.

min.

9. Birthplace WASHINGTON, MD.

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

own home

MOTHER FATHER

12. Name BERNARD O'DONNELL

13. Birthplace PA.

14. Maiden name BRIDGET GLEASON

15. Birthplace IRELAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND MD.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 6, 1946
(month) (day) (year)

Cemetery or crematory St. Peter & Paul Cemetery

Location Cumberland, MD.

18. Funeral director

Address

Nov. 5, 1946

(Date rec'd by registrar)

John J. Hole

Cumberland, MD.

J. P. Franklin, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PA.

County WASHINGTON

City or town W. BROWNSVILLE, PA.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 MIDDLE ST.

(If rural, give LOCATION)

2.(a) If veteran, name was

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 3

1946 at 10:22 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

October 9 to November 3, 1946.

and that I last saw her alive on November 3, 1946.

Immediate cause of death

Carcinoma of right breast.

Due to

DURATION

Due to

2 years.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland Ave Date signed 11-4-46

13 JUN
KREAU & C.

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-8)

CERTIFICATE OF DEATH

1★683

Reg. Dist. No. 4

1. PLACE OF DEATH:

County

Allegany Cumberl^{and}

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

47 Elder St.

How long in hospital or institution?

3. (a) FULL NAME

Mary Albine Gabradka

3. (b) Social Security Number

None

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

Frank J. Gabradka

7. Birth date of deceased (mo., day, yr.)

May 12, 1874

B. (c) If alive, give age _____ years

8. AGE:

Years Months Days If less than one day

72 6 1 hrs. min.

9. Birthplace

Prague, Bohemia

(Town, county, and state)

10. Usual occupation

11. Industry or business

Father Francis Gabradka

13. Birthplace Bohemia

Mother Father

14. Maiden name Unknown

15. Birthplace

16. Informant Francis W. Gabradka

Address Cumberl^{and}

17. Burial Burial

Date thereof Oct 16, 46

(month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Cumberl^{and}

18. Funeral director Louis Stein

Address Cumberl^{and}

19. Date rec'd by registrar Nov. 14, 1946

J. P. Faulchi, M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Cumberl^{and}

(If outside city or town limits, write RURAL and give nearest town)

Street No. 47 Elder St.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1946 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15, 1946 to Nov. 13, 1946

and that I last saw her alive on Nov. 13, 1946

Immediate cause of death Coronary

Or chronic -

Due to Cardiac Vasculitis

3 yrs

renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide, Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W.E.B. Owens

M. D. or other

Date signed 11/14/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10684

140

Reg. Dist. No.

1. PLACE OF DEATH: Allegany

County.....

City or town.....

Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

4 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Forrest Edward Zeigler

4. Sex

Male

5. Color or race

White

B.(a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Jan. 26, 1906

B.(c) If alive, give age..... years

8. AGE:

Years
40Months
10Days
1If less than one day
hrs. min.

9. Birthplace..... Pittsburgh, Pa.

(Town, county, and state)

10. Usual occupation..... None (invalid)

11. Industry or business

12. Name..... Owen Zeigler

13. Birthplace..... Penna

14. Maiden name..... Hattie Kimmel

Stoystown, Pa.

15. Birthplace.....

16. Informant..... Mrs. Mabel Krampf

Ellerslie, Md.

Address..... Burial

Date thereof..... Nov. 20, 1946

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory..... XXXXX Stoystown

Location..... Stoystown, Pa.

18. Funeral director..... Harvey H. Zeigler

Address..... Hyndman, Pa.

19. Date rec'd by registrar..... Nov. 30, 1946

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Ellerslie (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 27, 1946

19. at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1 to 1946, to Nov. 27, 1946

and that I last saw h. alive on Nov. 27, 1946

Immediate cause of death..... Broncho-pneumonia

DURATION

7 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)?

Means of injury.....

Injured at work?

23. SIGNATURE..... John A. Tupper MD

M. D. or other

Address..... Hyndman, Pa.

Date signed 11/29/46

RECEIVED

DEC 12 1946

BUREAU U.S.

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10685

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

143 Fredrick St.

How long in hospital or institution?

3. (a) FULL NAME

William R. Zimerla

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife..... Harriet (Weber) Zimerla

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1873 6.(c) If alive, give age years

8. AGE: Years 73 Months I Days 28 If less than one day hrs. min.

9. Birthplace..... Cumberland, Md. (Town, county, and state)

10. Usual occupation..... Parking Lot Watchman

11. Industry or business Cumb. - Parking Lot

12. Name..... Geo. W. Zimerla

13. Birthplace..... Md.

14. Maiden name..... Lula Mundel

15. Birthplace..... Md.

16. Informant..... Geo. Zimerla

Address..... Cumberland, Md.

17. Burial Date thereof Nov. 20, 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Trinity Lutheran Cem.

Location..... Cumberland, Md.

18. Funeral director..... Louis Stein Inc.

Address..... Cumberland, Md.

19. Nov. 20 1946 J. P. Franklin, M.D.
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Allegany

City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No..... 143 Fredrick St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 18 1946 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h. im. alive Dead Nov. 18 1946

Immediate cause of death.....

Coronary sclerosis and insufficiency.

Due to..... Arterio-sclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

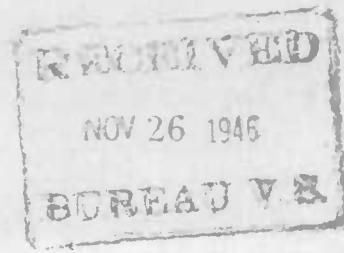
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Deputy Medical Examiner All Injured at work?

23. SIGNATURE H. V. Deming, M.D. 4-V. Dering, M.D.
M. D. or other

Address..... Cumberland, Md. Date signed 11-15-46



Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

DR. MIRKIN

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

59
3/21
116844

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

ONE DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 332 N. MECHANIC ST., CITY

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(b) Social Security Number

None

3. (a) FULL NAME

MRS. MYRTLE ZINN

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALE

WHITE

WIDOWED

6.(b) Name of husband or wife

ZINN, EMANUEL E.

7. Birth date of deceased (mo. day, yr.)

APRIL 19 1890

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

56

7

20

hrs.

min.

9. Birthplace

MARYLAND, Meyersdale, Pa.

(Town, county, and state)

10. Usual occupation

HOUSE WIFE

11. Industry or business

own home

MOTHER FATHER

12. Name

SECHRIST, GEORGE

13. Birthplace

PA.

14. Maiden name

Myrtle

15. Birthplace

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MARYLAND

17. Burial

Date thereof Dec 3 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Meyersdale Union Cemetery

Location

Meyersdale, Pa.

18. Funeral director

John J. H. Jr.

Address

Cumberland, Md.

19. Nov 30 1946

Joseph D. Franklin

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 30

19 46, 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 46 to Nov 30 1946

and that I last saw her alive on 29 Nov 1946

Immediate cause of death

Probable pulmonary embolism

Due to Hypertensive & arterio sclerotic heart dis.

Arteriosclerosis

DURATION

Died.

2 Other conditions 1) Nephrosclerosis, 2) edema. 2) Gangrene leg 3 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 115 S. Centre St Date signed 11/30/46

RECEIVED

DEC 3 1946

BORRATED

1-35